

HARVARD MEDICAL

ALUMNI BULLETIN

FALL 1985



Class Day
Alumni Day
1985

2 Ways To Honor Extraordinary Achievements



■ Put Harvard University on Wedgwood China and you have an heirloom quality collection instantly. Each set cast directly at the Josiah Wedgwood factory in England shows eight different 20th Century views in a lovely mulberry rose pattern on cream.

SHOWN: The Widener Library Views include — Harvard College Gate, Holden Chapel, Hollis Stoughton, Harvard Houses from the Business School, Straus Library at the School of Business Administration, Memorial Hall and Langdell Hall at the Law School.

Set of Eight, \$200

Limited quantities from the 19th Century Collection also available.



■ The Classic Harvard Captain's Chair with the Medical School seal in gold is designed specifically to honor your achievements. Constructed of quality northern hardwood with maple-finish arms and gold trim, it's a faithful reproduction of its 19th Century original and only available through the Harvard Coop.

Also available in all maple

\$175

HARVARD
COOPERATIVE
SOCIETY

**the
Coop**

HARVARD MEDICAL

ALUMNI BULLETIN / FALL 1985 / VOL. 59 NO. 3

FEATURES

- 10 **Class Day**
13 **Teachers**
by Rebecca Wurtz
14 **No Sleep is a Scary Thing**
by Fred Orlando
15 **A Soft Touch**
by Harlan Krumholz
17 **Ties That Bind**
by Arnold N. Weinberg
19 **Values and Professions**
by Paul Tsongas
22 **Alumni Day**
24 **The Veritas Imperative**
by Roger J. Bulger
27 **30th Reunion (poem)**
by Susanne E. Learmonth
28 **The Metamorphosis of "Patient" into "Client": A Morbid Mutation**
by Donald S. Gair
31 **Is 60 Minutes Enough? Are We Bottom-Liners?**
by Robert L. Replogle
35 **An Overland Odyssey: From the Muddy to the Ohio River**
by David P. Segel
37 **How in the World Did I Get Here?**
by Walden B. Whitehill
40 **Don Bowen: Bridging the Gap Between Two Nations**
by William Fletcher
43 **Where's Charlie?**
by J. Gordon Scannell

DEPARTMENTS

- 2 **Inside HMAB**
3 **Pulse**
8 **Alumni Council**
45 **Reunion Reports**
52 **Alumni Notes**
61 **In Memoriam: Joseph T. Wearn, Marlon Sellers, Edward J. Riseborough**
63 **Death Notices**

Cover: Michael Landzberg '85 with family members. Photograph by Jerry Berndt.

All Alumni Day and Class Day photos by Jerry Berndt.

Blessed by long-established decree of the weather-god, Alumni Day came in warm and clear. The daughters and sons of Harvard Medical School once again were reminded of the joy of a New England day in June—something you feel you have earned. What is so rare as?

Promptly at 9:30 A.M. the wandering pilgrims, their labels proclaiming their vintage like old wine in new bottles, gathered before the lion rampant in the big tent. Roger Bulger '60 led off with a hymn to truth—"Veritas" he called it, in deference to the surroundings. He ended with a swig of hemlock. Fellow speakers followed with down-to-earth questions such as, How did I get here?, What am I doing anyway?, and Are we becoming a nation of shopkeepers? It was a folksy morning sitting around the academic cracker-barrel. This is where the new pathway of 25 years ago has led.

On Class Day three students made graceful exits for the Class of 1985. Their joys and anxieties are duly recorded. Arnie Weinberg '56 demonstrated his special communion with students by talking about the tie that binds, a crafty weave of nostalgia and good common sense. Paul Tsongas was the principal speaker. He spoke with the prescience of one who has been there, all the way from the U.S. Senate to the Valley of the Shadow as interpreted by a graduate of Yale Law School. He spoke about values, and his message runs deep.

We have a bonus in this issue, a poignant account of one of our Native American graduates, Don Bowen '76, a citizen of the Creek Nation. He was taken away from his people alas too young, victim of the tragic fate that befell Soma Weiss, and at about the same age.

And then you will have to bear with me. Your editor indulges his crusading passion to get Charlie off the M.T.A.

We close with praise of a famous man, Joe Wearn '17, sometime dean of Western Reserve but long ago a stalwart of the Thorndike in the days of Francis Peabody. Exeunt.

—Gordon Scannell

HARVARD MEDICAL

ALUMNI BULLETIN

Editor

J. Gordon Scannell '40

Managing Editor

Lisa W. Drew

Assistant Editor

Lisa Derman

Editorial Assistant

Donna Gordon

Editorial Board

Harold Amos, Ph.D.

A. Clifford Barger '43A

Ethan Canin '88

Enrique Carrazana '87

Robert M. Goldwyn '56

Timothy E. Guiney '66

Robert S. Lawrence '64

Guillermo C. Sanchez '49

Eleanor Shore '55

Richard Warren '34

Design Direction

Office of the University Publisher

Association Officers

Clement A. Hiebert '51,
president

James A. Pittman Jr.,
president-elect

D. Kay Clawson '52,
past president

David E. Marcello Jr. '56,
vice president

Lon E. Curtis '56, secretary

John D. Stoeckle '48, treasurer

Councillors

George M. Bernier Jr. '60

Barbara E. Bierer '80

David R. Challoner '60

Martin L. Greene '65

Adolf W. Karchmer '64

Diane Kittredge '72

Paul G. Ramsey '75

Benson B. Roe '43A

Claire M. Stiles '56

Representative to the

Harvard Alumni Association

W. Bradford Patterson '50

Director of Alumni Relations

William D. Cochran '52

Chairman of the Alumni Fund

Joseph E. Murray '43B

The *Harvard Medical Alumni Bulletin* is published quarterly at 25 Shattuck Street, Boston, MA 02115 by the Harvard Medical School Alumni Association. Telephone: (617) 732-1548. Third class postage paid at Boston, Massachusetts. Postmaster, send form 3579 to 25 Shattuck Street, Boston, MA 02115. ISSN 0191-7757.

From Idea to Marketplace

The development of artificial skin, the discovery of the link between polyacrylate rayon in tampons and toxic shock syndrome, the structure of a hormone released by the heart that regulates fluid balance in the body: all are forms of property—property to be defined, patented, licensed, and put into use.

What happens to such property, and the process of bringing its promise to fruition for the public at large, is the business of HMS's Office of Technology Licensing and Industry-Sponsored Research (OTL), established in May 1984. "The office symbolizes the serious commitment of the medical school and the dean," says OTL director Stephen Atkinson, "to the translation of creative ideas that originate here into products and processes that will benefit the public."

This summer, OTL distributed the first HMS *Guide to Protecting and Managing Intellectual Property* to more than 200 researchers affiliated with HMS and Harvard School of Dental Medicine. A unique publication that has already attracted wide interest in academia and industry, it offers concise information on patents, copyright, agreements with industry, and university policy. The 22-page guide and its seven appendices cover discoveries, inventions, and works to be published—with special sections on computer software and biological materials.

Once a scientist has determined, sometimes with the help of OTL's attorneys, that his or her property may be patentable, OTL helps apply for the patent and negotiates licensing arrangements with industry. One of OTL's dozen or so current negotiations, for example, is based on the discovery by Edward Kass's Channing Laboratory group that polyacrylate

fibers in tampons bind magnesium, thereby making a favorable environment for the staph infection responsible for toxic shock syndrome (TSS). The finding suggests a way to design and construct a tampon that could significantly reduce the incidence of tampon-related TSS. "It is clearly a real advance in terms of improving a biomedically-related product," says Atkinson.

The other kind of industry support OTL plans to encourage takes the form of funding in exchange for a "window on science." An example of such an agreement is the existing 10-year, \$13 million grant from Du Pont, awarded in June 1981, to help support Philip Leder's work in the Department of Genetics. The Du Pont contract is carefully worded to protect academic freedom: the lab directs the course of its own research, and is free to communicate and publish results.

Among its other endeavors, OTL is currently developing two data bases. The first is a directory of current research at the school, conducted by Larry Bonar, assistant director for technology evaluation. Bonar has been systematically interviewing scientists to compile the first complete directory of HMS and HSDM research activities. The second is a survey of biomedical industries, conducted by Carol Taylor, assistant director for marketing. OTL plans to cross-reference the two data bases to facilitate matching of research projects with companies interested in licensing or support agreements. □

Gifts From Grateful Patients

A fund started 16 years ago by a grateful patient has resulted in a new professorship named for William V. McDermott '42, now stepping down as chief of surgery at New England

Deaconess Hospital. Surgical oncologist and tumor immunologist Glenn D. Steele Jr., his successor, has been named the first William V. McDermott Professor of Surgery. McDermott has spent his entire career affiliated with HMS (except for his military service and a year's fellowship at NIH); he has headed a Harvard surgical service for 20 years, first at Boston City Hospital and then, when the service relocated in 1973, at NEDH.

Endowment for the new professorship began in 1968 after McDermott performed major surgery on Raphael Recanati, a New York businessman involved in banking and international shipping. "I got to know Dr. McDermott well," says Recanati of the time he was under McDermott's care. "I admired not only his medical



William V. McDermott Jr.

skills, but also the care and handling of my case. Also, I'm interested in medicine and medical education and am anxious to assist in whatever way I can." Recanati made a donation that established the Harvard Surgical Services Fund, intended to support research in liver disease and related problems until McDermott's retire-

ment, when it would convert to a professorship in his name.

Four years ago, when McDermott announced his intention to retire, Recanati made another large gift, as did another patient, Norman Hascoe, founder of a Connecticut semi-conductor company. "In addition to being a wonderful guy and a fantastic doctor, he saved my life," says Hascoe. "It would take a volume to tell you how I feel about him. He's done such good for so many people." More than 350 other patients, friends, professional associates, and graduates of the BCH and NEDH surgical training programs gave contributions totaling over \$725,000.

"I am delighted I could serve as an instrument to help find that funding for Harvard," says McDermott, who plans to remain active as Cheever Professor of Surgery and a member of the NEDH surgical staff. "Because it's now 50 years since I first entered Harvard College, and because my father, a neurologist with the same name, graduated from HMS in 1896, I feel extremely warmly about having a Harvard professorship named after me. This is the nicest sort of recognition I could get."

McDermott's studies of the liver—



Glenn D. Steele Jr.

its cell function, circulation, failure, problems involved in transplantation, and complex interrelations with the central nervous system and kidney—have enabled physicians to deal effectively with hepatic diseases. Under his direction the surgical residency training program grew from three residents at BCH to approximately 50, now involving the Cambridge, Faulkner, Manchester VA, and Mt. Au-

burn hospitals, in addition to NEDH. New surgical programs have been established in nutrition and metabolism, and organ transplantation; and in 1983 NEDH launched its liver transplantation service. NEDH is now a leader in gastric bypass procedures, nutrition support services, and transplantation immunology.

As the new chief of surgery, Steele plans to continue the expansion, beginning this fall with a new pancreas transplantation program to treat diabetes. He hopes eventually to devise a small-intestine transplant—though realization of that goal is still years off. He also plans to design a new systemic treatment protocol for cancer patients whose disease may have spread by the time their solid tumors are surgically removed.

Steele has spent many years working toward a vaccine that will prevent recurrence of colorectal and other gastrointestinal cancers. In the early 1970s, as an NIH fellow, he devised a rat model of colon cancer with colleague Hans Sjogren in Sweden. Among the many antigens on the surface of colon tumor cells they found several common to all rats bearing colon tumor, even when the tumors had been induced by different chemicals. They hypothesized, and then confirmed, that the shared ("cross-reacting") antigens were involved in organ differentiation during fetal development, and were switched on, or de-repressed, by the carcinogen.

Steele and Sjogren then made vaccines from various antigens, inoculated animals, and exposed them to carcinogens. Those inoculated with vaccines made from cross-reacting colon-cancer antigens grew fewer tumors than those inoculated with vaccines made from antigens from another organ or from non-cross-reacting tumor-associated antigens.

When Steele became associated with HMS, Brigham and Women's Hospital, and Dana-Farber Cancer Center in 1976, he and colleagues refined the animal model to more closely resemble human colon cancer. They also identified colon-cancer antigens to which the tumor bearer is already making antibodies. Last year they inserted these antigens into liposomes (fat globules which boost the immune response), which they then injected into animals. They found a mixed reaction: some antibodies attacked tumor cells, while others bound to them to protect them. This year they will resume the work, hoping to find a way to control the immune

HARVARD

An Architectural History

Bainbridge Bunting

Completed and Edited by
Margaret Henderson Floyd

Here is the entire history of Harvard's architectural development, written by distinguished architectural historian Bainbridge Bunting, and completed by Margaret Henderson Floyd. This fully illustrated book examines how changing educational goals brought complex architectural requirements to Harvard's campus.

226 halftones, 24 line illus., 1 table



Belknap \$30.00 at bookstores or from **Harvard University Press**

79 Garden Street, Cambridge, MA 02138



Taste. It's imperative.

*They know how important it is to begin well.
And it shows in all the choices they make.
Because they look only for value that will
stand the test of time.*

Behind every Gregorian label
you'll find value worthy of the name!
An oriental rug that's authentically
old world, fashionably new world
and steeped in character!
A proud possession hand-selected
by experts, certified genuine
and protected by a lifetime
exchange policy.

Surprisingly, many Gregorian
oriental rugs are priced from just
a few hundred dollars. A copy
of the new Gregorian Catalog
is yours for the asking—
write us for it today!

Authenticity. It's imperative, too.

*While the renowned Gregorian
Collection of Antique Oriental
Rugs may be viewed at univer-
sities and museums around the
country, any one of 6,000
genuine, yet affordable
Gregorian Orientals may
become yours at the Newton
Lower Falls showrooms.*



Arthur T.
Gregorian Inc.
Oriental Rugs

2284 Washington Street. Newton Lower Falls.
Massachusetts 02162 (617) 244-2553

Just 15 minutes from Downtown Boston on Rte. 16 — Exit 54 W off Rte. 95 (128).

response so no tumor cells are protected.

Currently, the team is producing monoclonal antibodies to colon carcinoma antigens; by mixing these antibodies with patients' serum, they can detect antigens that indicate the occurrence or recurrence of colon cancer. They are also imaging human tumors in experimental animals by radioactively marking a monoclonal antibody to the tumor, injecting the antibody, and then viewing the results with a nuclear medicine scan. In collaboration with Lan Bo Chen, associate professor of pathology, the team is investigating treatment of colon cancer in animals by injecting lipophilic (fat-soluble), cationic (positively charged) compounds (see "The Making of a Scientist," Summer 1985). □

Kroc Chair to Weiner

When the officers of the Kroc Foundation decided to endow a professorship in neurological diseases, they chose Howard L. Weiner, then associate professor of neurology, as its first incumbent. Two years ago Weiner led a team that demonstrated for the first time a therapy that can bring one- to two-year improvement or stabilization in patients with severe progressive multiple sclerosis.

The Robert L. Kroc Professorship in Neurological Diseases is one of three new chairs established by the Kroc Foundation of Santa Barbara, California, as part of its dissolution process. Established and endowed

solely by the late Ray A. Kroc, founder of the McDonald's restaurant chain, the foundation has given more than \$52 million for biomedical research, concentrating its grants in diabetes, rheumatic diseases, and MS. "My brother Ray was a diabetic and also suffered from rheumatoid and osteoarthritis," explains Robert L. Kroc, the foundation's president. "Our sister Lorraine, while still quite active, has MS. We had firsthand knowledge of the impact of those diseases on patients, and wanted to do something to help."

MS—a chronic inflammatory disease of the central nervous system—afflicts about 250,000 Americans, causing weakness or numbness of the limbs, visual impairment, slurred speech, and sometimes poor bladder and bowel control and sexual dysfunction. Those with a mild, stable form of the disease may suffer only minor neurological impairment; others have multiple acute attacks. Still others suffer from severe progressive MS, which can lead to complete disability within 10 years.

In a controlled study, Weiner and colleagues found that short-term, intensive treatment with cyclophosphamide (a drug used in chemotherapy), given in conjunction with ACTH (a pituitary hormone known to shorten the duration of acute MS attacks), temporarily halts disease progression or improves function in 60 to 70 percent of patients with severe progressive MS. The published results, says Weiner, "created a reasonable stir, largely because it was a drug that any physician could obtain and use."

"Cyclophosphamide is not the

cure for MS," he emphasizes. "It does not help everyone, it has toxic effects, and it is not as selective immunologically as we would like." Weiner says he and coworkers are now trying to control the disease "by more specifically targeting the lymphoid elements—the T cells—involved."

The team has discovered that in the blood of about one-third of MS patients, the proportion of suppressor cells (marked by T8) to helper cells (marked by T4) decreases during an acute attack, and then returns to normal. Having found the opposite imbalance (too large a proportion of T8 cells) in the brains of MS patients, Weiner and colleagues hypothesize that T8 cells migrate to the brain during an attack, producing neurological damage. The group is



Howard Weiner



Robert L. Kroc presenting check to Dean Tosteson

now experimentally treating MS patients with mouse monoclonal antibodies directed against T-cell markers including T12 and T11 (present on all T cells) and to T4, hoping eventually to find an immunologically specific, non-toxic therapy.

Weiner and colleagues have also recently demonstrated the presence of activated T lymphocytes in the blood of patients with severe progressive MS. This finding may prove useful in identifying patients who should receive therapy and in monitoring their response to it.

In addition to its ongoing MS research, the team is studying Alzheimer's Disease and amyotrophic lateral sclerosis—all at the recently established Center for Neurologic Diseases located in the new Biosciences Research Building at Brigham and Women's Hospital. Other work in the

lab includes studies of relapsing experimental allergic encephalomyelitis (an animal model for MS), the immune function of cells in the nervous system, surface structures on the motor neuron, and viral-induced autoimmunity in neurological disease.

The other two Kroc Professorships were awarded to Edward Goetzl (HMS '66), Medical Center of University of California, San Francisco (Rheumatic and Connective Tissue Diseases) and Paul Lacy, Washington University School of Medicine in St. Louis (Diabetes and Endocrine Diseases). All three chairs are named for Robert L. Kroc, a former professor of zoology at Indiana University, an endocrine researcher, and director of physiology for the Warner-Lambert Company. He has developed anti-inflammatory drugs, blood coagulation reagents, and new drugs in the fields of thyroid and reproductive physiology. □

Grossman First Dana Professor

Patients suffering from congestive heart failure (CHF) or angina pectoris can take heart in response to findings by William Grossman, recently appointed the first Herman Dana Professor of Medicine. Chief of cardiology at Beth Israel Hospital since 1981 and editor of *Cardiac Catheterization and Angiography*, Grossman has shown that some cases of CHF and angina are due to incomplete dias-

tolic relaxation of the heart, for which he and colleagues have come up with a treatment.

The new chair Grossman occupies is the gift of the late Herman Dana, a Boston real estate developer, BIH trustee, and author of *The Early Days of the Beth Israel Hospital, 1911-1920*. His father, Myer Dana, served as BIH president from 1918 through 1920, raising \$100,000 for hospital improvements. Myer, a Lithuanian emigrant who started out in this country in the early 1890s selling 15-cent spools of thread on the installment plan, founded a commercial real estate venture in Boston's Hyde Park area in 1910. Herman and his siblings Gertrude and Lester joined in the business, soon followed by Lester's son Marshall (also a BIH trustee) and, in 1972, by Marshall's son Myer R. Dana (who currently chairs a committee overseeing major construction at the hospital). Other Dana family gifts support research at BIH and provide scholarships for students at Harvard College, Law School, and Medical School.

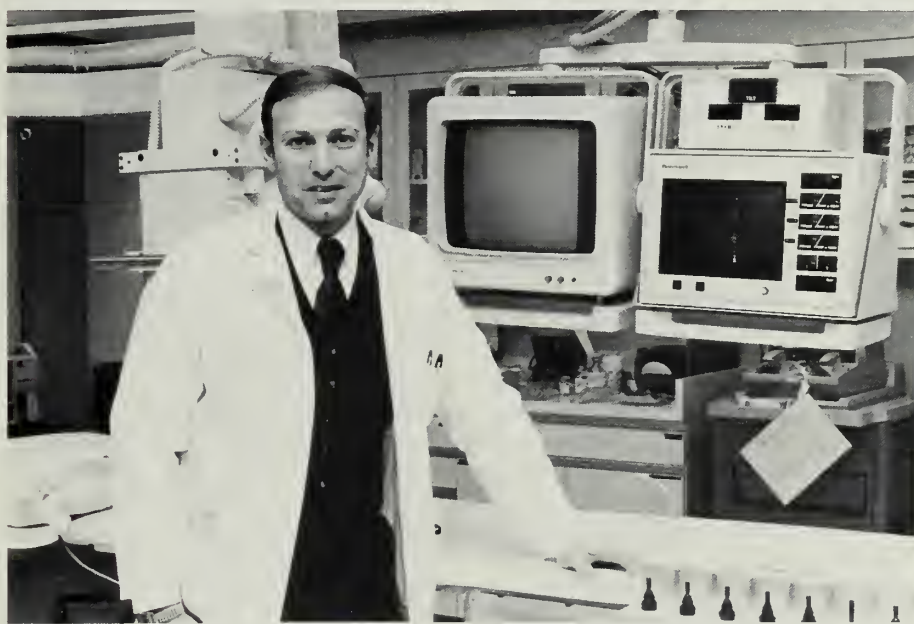
In congestive heart failure the circulating blood backs up behind the heart, often leading to fluid buildup in the lungs. Before Grossman's studies, research and treatment of CHF had focused on the contraction phase of the heartbeat; the treatments of choice were digitalis and its derivatives, which strengthen cardiac contractions.

In the 1970s Grossman noticed that the hearts of some CHF patients had no difficulty ejecting blood. He

hypothesized that the problem lay in the heart's inability to receive blood at low pressure in diastole (the relaxation phase of the heartbeat). After several years of research, he and colleagues identified two broad categories of diastolic failure: loss of muscle elasticity due to anatomic pathology such as scarring or infiltration of the muscle, and inability of the heart muscle to relax completely.

Grossman and coworkers found that impaired diastolic relaxation often accompanies angina pectoris—chest pains that occur when the coronary arteries temporarily provide insufficient blood to the heart. "Angina and its accompanying increase in diastolic stiffness of the left ventricle can appear and disappear within minutes," Grossman says. "This gave us a clue that some cases of diminished elasticity might have a biochemical rather than anatomical basis."

After experimentation on dogs, pigs, and isolated rabbit hearts, Grossman and colleagues discovered they could correct many cases of incomplete cardiac relaxation with the calcium channel blocker nifedipine, which limits the amount of calcium that can enter heart cells. Calcium ions stimulate the heart muscle to contract; when the sarcoplasmic reticulum (a network of membranes within the cell) sequesters these ions, the heart relaxes again. Nifedipine is especially helpful in patients with CHF due to hypertrophic cardiomyopathy—in which heart contractions increase in strength, and cardiac relaxation is incomplete. Grossman hypothesizes that this condition is due to loss of the sarcoplasmic reticulum's ability to take up calcium quickly or completely. The fact that digitalis, which increases the amount of calcium entering the cell, often worsens hypertrophic cardiomyopathy supports his hypothesis.



William Grossman

handwoven rugs
 orientals • kilims • dhurries
 tapestries • folk art



decor international
 171 newbury st • boston • 262-1529

In related work, Grossman has identified the mechanism behind cardiac hypertrophy, in which the heart muscle enlarges in one of two ways, from pumping more or harder than usual. Eccentric hypertrophy is known to result from volume overload, an increase in the amount of blood to be pumped (due to either normal growth of a young animal or leaky valves). Grossman has discovered that in this form of hypertrophy the muscle fibers elongate by adding new muscle in series, producing an enlarged heart with the same proportions as a normal one. Concentric hypertrophy is a response to pressure overload—pumping against greater resistance than usual, such as that caused by high blood pressure or a narrowed valve. In the concentric form, Grossman has found, new muscle fibers are laid down in parallel, thickening the heart wall.

Grossman and colleague Stephen

Gunther have discovered that in some cases of pressure overload, the problem is too little hypertrophy. For example, in cases of aortic stenosis, if the heart hypertrophies sufficiently to overcome the resistance posed by the narrowed aortic valve (the outlet from the heart to the arteries), the patient experiences only minimal symptoms and is said to be in “compensated” congestive heart failure. If, however, the heart does not hypertrophy enough, the patient experiences symptomatic, “decompensated” CHF. Surgery for aortic stenosis is the second most common heart operation in the elderly (after coronary bypass). □

Note: The illustration on page 42 of the Summer 1985 Bulletin is by Jamie Hogan. Her credit line was accidentally left off the page.

ALUMNI COUNCIL

With this issue, we introduce Alumni Council reports written by members of the council. We start with a message from past-president Kay Clawson, who was succeeded by Clem Hiebert on Alumni Day. We also provide a list of this year's councillors and their addresses.

A Letter from the Past President

I wish to thank those of you who took time from your busy schedule to write to me during my tenure as president expressing your concerns and questions, and giving your support. The vast majority of the correspondence centered around the admissions process and the educational program within the medical school itself. Each letter was reviewed by members of the Alumni Council and the appropriate member of the dean's staff. They were answered in an open

manner and we all appreciated hearing from you.

The fact that there are so many alumni we do not hear from led the Alumni Council to request the Alumni Survey Committee to conduct an in-depth study to find out why some are so active and involved, yet others are not. We will look forward to receiving the report of that committee during the coming year and hope that those of you contacted by questionnaire or telephone will let us know exactly how you feel about your alma mater.

The Alumni Council has had some exciting times with the transition of the directorship of alumni relations from our beloved Perry Culver to Willie Cochran. The unusually smooth transition was due to the understanding and efforts of all in the Alumni and Dean's Office staff as well as to the affable and able approaches brought to the job by Willie.

We have watched the transition in the Development Office under the stabilizing effects of past-president Joseph Murray, and after a very thorough and extensive search for the most able person to follow Carl Walter as chairman of the Alumni Fund, it became very clear that Joe Murray was indeed that individual. We are delighted that he has accepted the position.

In our efforts to find a hospitable home for the Alumni Association, we are delighted to report that Dean Tosteson has agreed that by 1987 a number of space moves will be completed. We will then be able to have all alumni activity—including the Alumni Office, the chairman of the Alumni Fund, and the *Bulletin* office—once again housed together in Building A.

Thanks to the efforts of a number of dedicated alumni, including Tom Warthin '34 and Sergeant Cheever '36, we have uncovered and addressed a flaw in our nominating process that had potential to exclude a very significant segment of our alumni—those in the older pentads. Your Alumni Council made specific adjustments in the nominating process for this year, but also has appointed a committee to look at potential changes in the constitution or bylaws to ensure appropriate representation from all groups of alumni in the future.

As we move to the latter part of the 1980s, it is increasingly clear that with the crisis we are seeing in medicine and medical education, it is more essential than ever that we look at new ways of providing a better education for future physicians. Your Alumni Council strongly supports the dean and faculty in the development of the New Pathway. I personally hope it is as successful as I believe it will be, and that it can be extended to a broader number of students.

Finally, one only has to spend a short time in the magnificent Quadrangle to recognize that the lovely facilities, built in 1906, are in tremendous need of refurbishing and expansion. In this regard, I look forward to working with all of you and our dean in an effort to raise the necessary capital to ensure that HMS can continue its leadership in education, research, and scientific medicine while maintaining an environment that will develop the qualities of creativity, caring, and compassion so essential in the physician.

It has been my pleasure to have served you and my alma mater this

past year as your president and I look forward to continuing opportunities to serve HMS.

—D. Kay Clawson

You can contact your councillors at the following addresses:

Officers

Clement A. Hiebert '51, president
President, Maine Medical Center staff
321 Brackett Street
Portland, ME 04102
(207) 774-5745

D. Kay Clawson '52, past-president
Executive Vice Chancellor
University of Kansas College of
Health Sciences and Hospital
39th and Rainbow Boulevard
Kansas City, KS 66103
(913) 588-1207

James Allen Pittman Jr. '52,
president-elect
Dean and Professor of Medicine and
Physiology
University of Alabama School of
Medicine in Birmingham
University Station
Birmingham, AL 35294
(205) 934-1111

David E. Marcello Jr. '56,
vice-president
Clinical Professor of Surgery
Boston University Medical School
61 Libby Street
Brockton, MA 02402
(617) 587-5000

John D. Stoeckle '48, treasurer
Chief, Medical Clinic
Massachusetts General Hospital
Fruit Street
Boston, MA 02114
(617) 726-7930

Lon E. Curtis '56, secretary
Associate Professor of Surgery and
Associate Dean for Student Affairs
Tufts University School of Medicine
171 Harrison Avenue
Boston, MA 02111
(617) 956-5587

Councillors

George M. Bernier Jr. '60
Professor and Chairman
Department of Medicine
Dartmouth-Hitchcock Medical
Center
Hanover, NH 03756
(603) 646-7684

Barbara E. Bierer '80
Clinical and Research Fellow in
Hematology
Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115
(617) 732-6780

David R. Challoner '60
Professor of Medicine and
Vice President for Health Affairs
Box J-14, JHMHC
University of Florida
Gainesville, FL 32610
(904) 392-2761

Martin L. Greene '65
Clinical Associate Professor of
Medicine
University of Washington School of
Medicine
515 Minor Avenue
Seattle, WA 98104
(206) 623-6600

Adolf W. Karchmer '64
Associate Professor of Medicine,
HMS, and Chief, Infectious Disease
Division
New England Deaconess Hospital
185 Pilgrim Road
Boston, MA 02215
(617) 732-9480

Diane Kittredge '72
Clinical Assistant Professor of
Pediatrics
Children's Memorial Hospital
P.O. Box 26901—Pediatrics
Oklahoma City, OK 73190
(405) 271-6821

W. Bradford Patterson '50
Director for Cancer Control
Dana-Farber Cancer Institute
44 Binney Street
Boston, MA 02115
(617) 732-3480

Paul G. Ramsey '75
Assistant Professor
University of Washington School of
Medicine
Department of Medicine RG-20
Seattle, WA 98195
(206) 543-3238

Benson B. Roe '43A
Professor of Surgery and Co-Chief
of Cardiothoracic Surgery
University of California,
San Francisco, School of Medicine
Moffitt, Room 488
San Francisco, CA 94143
(415) 666-2381

Claire M. Stiles '56
Professor of Clinical Anesthesia
University of Southern California
7601 Imperial Highway
Downey, CA 90242
(213) 922-7755



Harvard
Medical
School

1985-1986 Directory of Academic Appointments

A comprehensive listing of the 8000 Faculty Appointees at Harvard Medical School.

Listed by **Discipline** showing **Title, Academic Degrees, Hospital Affiliation.**

Price \$16.00
(Includes postage and handling)

Send
check or money order to:

Harvard Medical School
Faculty Services Office
25 Shattuck Street
Room #408
Boston MA
02115

To be
Shipped in
November
of 1985

BAHAMA OUT-ISLANDS *Barefoot Elegance*

On a small, tranquil, Bahamian island, nestled among the coconut palms, along a ridge of sand dunes, is the **ABACO INN**. Our ten very private cottage rooms overlook the Atlantic Ocean to the east and the Sea of Abaco to the west. From our informal clubhouse-lounge, where we serve elegant five-course dinners and a tropical buffet lunch, we have a beautiful view of pink sandy beaches and the breaking surf. The **ABACO INN** is a lifestyle — it's our home and we think it's very special. We offer a warm, leisurely, "away-from-it-all" atmosphere, as well as snorkeling; scuba diving (we're both divers); deep-sea reef and bonefishing; sailing; boating; windsurfing and trips to fishing and boatbuilding settlements on nearby islands. The Inn is just a pleasant walk from the picturesque 18th-century fishing settlement of Hope Town and the historic Elbow Cay Lighthouse. If you're searching for a unique personal experience; if you're in touch with nature and if you wish to escape the rigors of 20th-century urban life and yet retain the comforts, then we would like you to be our guests. Please write, via airmail, for our brochure, or telephone us for reservations and information.

Ruth Maury—
Jerry Whiteleather



ABACO INN

Box R1 Hope Town, Elbow Cay,
Abaco, Bahamas
Tel. 1-809-367-2666



Class Day

On Thursday, June 6, an army of fond relatives invaded the Quadrangle, aiming cameras at members of a smaller army of young people dressed in black gowns, mortarboards, and hoods lined with crimson. A few wore white armbands to protest apartheid in South Africa; all wore broad smiles.

A cheer arose as the clouds parted just a half hour before Class Day ceremonies began, and the high spirits continued through the program. "Arnie, Arnie," the Class of 1985 chanted as professor of medicine Arnold Weinberg began his speech. He responded by waving an assortment of bright-colored neckwear to

illustrate his topic, "Ties that Bind." Greeted by hoots and cheers from his classmates, Fred Orlando, one of the three student speakers, imitated comedian Rodney Dangerfield. "No respect at all," he complained, then proceeded to give advice for the new crop of interns: in conferences, he advises, BYOB. That stands for "Beep Yourself Out, Buddy."

Former senator Paul Tsongas commented on the student speeches before beginning his own address. "It must be a great honor for you parents," he said, "to spend \$60,000 to send your son or daughter to the pre-eminent medical school in the world, and then hear them speak at commencement and wonder whether they



spent four years at Harvard Medical School or nine months with Milton Berle." The three student speeches and Tsongas's and Weinberg's addresses can be found on the following pages.

In an unusual addition to the usual Class Day program, the Class of 1985 Graduation Choir—a group of 33 directed by Robin Avery '85—harmonized to the song "Loch Lomond," and finished with a rousing rendition of the spiritual "Ain't-A That Good News."

Carola Eisenberg, dean for student affairs, and Ronald Arky, Charles S. Davidson Professor of Medicine, elected by the class to assist with hoods, bestowed handshakes and kisses as class members waited for their names to be called. Elena Yanush-

polsky graduated accompanied by her toddler daughter, Ed Andujar by his dog Noop (with whom visitors to the Alumni Office may have become acquainted over the last four years), and Michael Landzberg by his baby daughter. When Dean Tosteson kissed her, dean for students and alumni Daniel Federman quipped, "This was our moment to see if the Senator [Tsongas] is going to run for office again."

Moderator Leslie Boyer Hassen '85 presented awards for outstanding preclinical and clinical teacher, respectively, to George Diamandopolis and Roger Christian. Diamandopolis, professor of pathology, was cited for his "expansive knowlege, philosophical approach, and gentle humor." Christian, instructor in surgery at



Rebecca Wurtz presenting class gift to moderator Leslie Boyer Hassen



Brigham and Women's Hospital, was cited for his "insight, kindness, and warm sense of humor." A special award to Sharon Clayborne, financial aid counselor, for her "unfailing helpfulness and cheerfulness," brought the graduates to their feet in a standing ovation. Finally, the moderator herself was given a gift by her classmates.

Seventeen students graduated cum laude, two graduated magna cum laude, and one summa cum laude—all in special fields. Ten prizes and awards were given in specific areas of achievement.

Robin Kimiko Avery, cum laude: "Visible and Invisible Worms: Concepts of Parasitism in Ancient Medical Literature." Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation, or scholarship in psychiatry: "The Interpersonal Theories of David Hume and Harry Stack Sullivan."

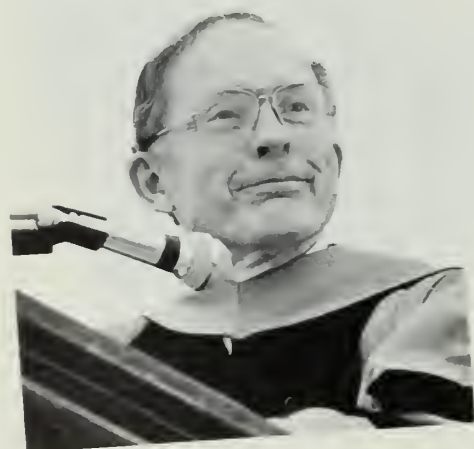
James Bonanno Bautz, Rose Seegal Prize for the best paper on the relation of the medical profession to the community: "HMO Enrollment of Medicare Recipients: An Analysis of Incentives and Barriers." J. Health Politics, Policy, and Law 1984; 9:41-62.

Bethany Rachel Block, cum laude: "Ultrastructural Studies of Immunolabeled Alzheimer Paired Helical Filaments."

Scott MacMillan Bradley, cum laude: "Increased Expression vs. Altered Product in the Activation of a Human Oncogene."

Raphael Bueno, cum laude and Henry Asbury Christian Award for notable scholarship in studies or research: "Role of the *glnB*, *glnD*, and *glnL* Products in the Regulation of Glutamine Synthetase and Nitrogen Metabolism in *Escherichia coli*."

Joan Reva Butterson, magna cum laude, "Education for a Medical Career: The Royal Navy in the Eighteenth Century." Richard C. Cabot Prize for the best paper on medical education or medical history: "The Education, Naval Service, and



Early Career of Dr. William Smellie (1697-1763)."

Rosa Maria Crum, cum laude: "Anti-angiogenesis by Steroids Without Glucocorticoid or Mineralocorticoid Activity in the Presence of Heparin."

Ann C. Duerr, cum laude: "Malaria: Mechanisms of Invasion into and Release from Erythrocytes."

Bengt Lennart Wilhelm Ivarsson, magna cum laude and Leon Reznick Memorial Prize for excellence and accomplishment in research: "In Vitro Construction of an Endothelialized Smooth Muscle Cell Tube with Potential as a Small Vessel Prosthesis."

Lynt B. Johnson, Kaiser/National Medical Fellowship Merit Award for outstanding academic achievement by a graduating minority medical student.

John Edward Jordan, cum laude: "A Benefit-Cost Analysis of Hypertension Treatment Programs: Implications for Targeting and Public Policy." Kaiser/National Medical Fellowship Merit Award for outstanding academic achievement by a graduating minority medical student.

Michael Jay Koren, cum laude: "Prophylaxis Against the Acid Aspiration Syndrome in Obstetric Patients: A Decision Analysis."

Dana Leifer, cum laude: "Applications of Monoclonal Antibodies and Tissue Culture Methods to Neurobiology."

Martin Gabriel Martin, Kaiser/National Medical Fellowship Merit Award for outstanding academic achievement by a graduating minority medical student.

Jeffrey Banks Matthews, cum laude and Harold Lampert Biomedical Research Prize for the best paper reporting original research in the biomedical sciences: "Exchange Diffusion and Non-acidic Chloride Transport in the Amphibian Gastric Mucosa."

Joan Whitten Miller, cum laude: "Identification of a G3PDH Subunit in Human Lens Proteins."

Edward Gerard Murphy, cum laude: "Patient Demand for Diagnostic Tests in a Primary Medical Care Setting."

Jed Gregory Nuchtern, cum laude: "The Effect of Exercise Conditioning on Cardiovascular Control in Hypertensive Patients."

Dale Craig Oates, cum laude: "Effect of Chronic Prostacyclin Infusion in Platelet Function and Smooth Muscle Cell."

Dennis Paul Orgill, cum laude: "Partial Regeneration of Mammalian Tissues Using Polymetric Materials."

Martin Raymond Prince, cum laude: "Selective Photo-removal of Atheromatous Arterial Obstructions."

Robert Sackstein, James Tolbert Shipley Prize for research, the results of which have been published or accepted for publication: "Subdivision of the S Region of the Mouse Major Histocompatibility Complex by Identification of Genomic Polymorphisms of the Class III Genes." J. Immunol. 1984; 20:321-330. "Molecular Regulation of MHC Class III (C4 and Factor B) Gene Expression in Mouse Peritoneal Macrophages." J. Immunol. 1984; 133:1618-1626. "Phylogenetic Conservation of a Class III Major Histocompatibility Complex Antigen, Factor B." J. Biol. Chem. 1983; 258:14693-14697.

John David Steichen, cum laude: "A Quantitative and Qualitative Study of Hematoporphyrin Derivative Localization in a Transplantable Canine Glioma Model."

Michael Aaron Weiss, summa cum laude: "Sequence-dependent Recognition of Nucleic Acids: NMR Studies of the Bacteriophage λ Receptor." □

Teachers

by Rebecca Wurtz '85



I thought of talking about the proper lithium dose to give an intern, but Dean Tosteson assures me that he will review the metabolism of lithium in his remarks; he has a reprint from *Scientific American* for each of us with our diplomas. So, even as we graduate, we see that some things will always be the same. Or, as the doctor said a few days after the boy swallowed the quarter, "No change yet."

In a few days we'll begin our internships, where the motto will be "leave no tern unstoned," and where, as our classmate Kenny Dressler put it, daytime will be something we see at night on TV. Internship will be hard, but I'm sure we'll survive, and survive with style. I've been impressed with my classmates' abilities to make the most of Harvard's advantages and to rise above its failings. I expect we'll do the same with internship.

Freddie Orlando is telling us in his address how to survive internship. I thought about talking about some of the issues we'll face as physicians—notably the cost of medical care, and a technology that outstrips our ethical ability to keep pace—but Harlan Krumholz said he'd cover issues. I decided to focus on teaching.

At most schools there's a saying that goes, "See one, do one, teach one," but we went to Harvard where it is, "See one, do one, publish it"—and sometimes the teaching is left out. We have had so many tremendous teachers, but some terrible ones, too. What separates the good from the bad? Some people are born with

the ability to teach poorly, but others work at it. We have all suffered at the hands of someone who seemed to work hard at teaching poorly, mainly by subscribing to the doctrine of immaculate perception. Sometimes it's been hard to tell if we're on a consult service or an insult service. The sad result of bad teaching is that we transfer our dislike of the teacher to the subject.

We honor the teachers we respect by going into their fields. I suspect that a disproportionate number of us will go into pediatric surgery, neurology, and infectious disease. We've had so many good teachers here. The word doctor means teacher, and plenty of people here have shown us by example how to be both doctor and teacher. Charlie Hatem taught us to praise in public and discipline in private. Dr. Diamandopoulos taught us the value of perspective, and Marty Samuels the value of humor. Arnie Weinberg taught us how to approach a complicated differential diagnosis, and life in general, when he said, "If we had eggs, we could have ham and eggs, if we had ham."

None of these people ever receive any substantial recognition for the time they take to teach. Some of our teachers were bad, some *very* good. They had all voluntarily taken time away from the jobs which bring them grant money, income, and fame. The best way to produce good teaching is for the people in charge to recognize it. The best way to recognize it is to

pay for it, and to consider it in tenure decisions. Some of my classmates will one day be in charge of departments, of hospitals, of medical schools; I urge them to make teaching count.

On another subject: the 155 students graduating today paid a total of six and a half million dollars for their medical educations. The Financial Aid office told me that as of June fifth we had borrowed \$3,439,325. Neither figure includes college costs or living expenses. On many of these loans, interest accumulates even as we graduate. Our education has cost us a great deal. Its cost influences who comes to Harvard and how and where we will practice, and that's too bad.

We owe another kind of debt to our families and friends, and I say on behalf of all of us, to all of you, that we are very grateful to you and we love you very much. □



No Sleep is a Scary Thing

by Fred Orlando '85



Here we are, at another graduation—number four or five for most of us. You would think we'd be experts at this by now. But something about this particular occasion scares me a little. High school graduation was rough; going into college was a big step. But a big part of starting college was life in the dormitory. It was important which dorm you got into, and who else was there. Mom worried about how you were getting along in the dorm. Even here, when we started Harvard Medical School, the dormitory, Vanderbilt Hall, took us all in.

"Dorm" in Latin means sleep. What frightens me about this graduation is that all of a sudden I don't hear any talk about dorm. Sleep is out of the picture. I'm nervous about internship. No sleep is a scary thing. For those of you who are also worried, I would like to share a few survival techniques I've picked up along the way. I apologize if my advice is a little too technical for some of my classmates' parents who are not physicians: I ask those four or five individuals to bear with me.

The smart intern is the efficient intern—and being efficient means squeaking enough time out of each day so you can grab a little food and a little sleep. So, my first bit of advice: beware of conferences. The conference robs one full hour of work time, which leaves one less hour to sleep. But the conference also means free lunch. So now we've got a problem: is a turkey sandwich and a bag of chips worth one full hour of sleep?

This is where an old and consistent enemy suddenly becomes your best friend. I'm talking about your beeper.

The key to getting the most out of conferences is BYOB. Remember what BYOB meant in civilian life? Well, in internship BYOB stands for "beep yourself out, buddy." Conference organizers know these conferences are no fun. That's why they trap us with free food in the first place. So: you're stuck in a conference. No problem. Just slide a hand under the table, hit the little red button, your beeper starts to sing, you look very disappointed as you grab a sandwich, and you're out of there! This is all legitimate. Remember, answering a page can mean saving someone's life; this time it happens to be your own.

Another part of house officer survival is looking intelligent. This doesn't mean having tons of knowledge. It means having style. Cyclic AMP is very stylish. No matter whose rounds, no matter what the question, cyclic AMP can be your answer.

There's always either too much cyclic AMP or too little. Nobody ever remembers—both sound real good—so the choice is yours. Surgery, medicine, ortho, psychiatry—it doesn't matter. Mumble something about cyclic AMP, and you have instant respect.

Another great tip for style is a unique Harvard phenomenon. This will really be a plus for the half dozen of us who are going to non-Boston hospitals. Before HMS, I would never have guessed that selectively using a French accent would be key to being a smart doctor. In grade school my ruler had inches on one side and centimeters on the other. I never used the centimeter. I still don't, because I'm from Harvard; now I exclusively use "sontameters." The sontameter is by far a much classier unit than the commonplace centimeter that everyday people use. Go to a hospital in Texas and say "sontameters." You'll be a star. You future surgeons: don't just talk about cleaning up a wound. Again, use the French: say "debreed-



As Kareem Abdul-Jabbar

mong." Nothing sophisticated about this advice; we're talking basic dollars and cents.

You know what else scares me? Some of this high-tech radiology stuff we're supposed to know. What I'm really talking about is ultrasound. Even the name is frightening. Think about it for a second. CAT scans are easy to read. That's why they have such a cute name. It could have been called a cobra snake scan, or the giant squid scan, but no, they're easy to get along with, so they're just CAT scans. There's even a new kind they're using now that sounds even friendlier: the PET scan. But then there's ULTRASOUND. Ultrasound, you can tell just by the name, is no pussy cat pet X ray.

I get ultra nervous when, after four ultra expensive years of medical school, I still cannot tell ultrasound pictures of kidneys from pictures of unborn babies from pictures of heart valves. It's scary. Just the other day I spent hours trying to get this echo stuff to make sense. I get this nice book on ultrasound, but the more I look, the more heart valves are looking like ovaries. Shaking my head, I look up to the television screen across my room, and sure enough, a small miracle. The guy on the tube is pointing at none other than a big ultrasound picture. Now I figure I got it made. I always learn better from television than from school books, so I run across the room and turn up the sound just in time to hear the guy say, "and as you can see from our satellite picture, there is a cold front from Canada sweeping over our area."

I say that when kidneys start looking like the weather forecast, there is no way to get this ultra business down. My advice: don't waste your time trying. If two months from now some hot-shot X-ray person asks you to interpret an ultrasound, just scratch your head, smile, and say "Gee, looks like we're in for some chilly weather."

When I thought of what to say at graduation, I realized what a special opportunity it was going to be. Over 150 future doctors assembled for one last time. Many of you have become my close friends. I wanted to say a few funny things, but more important, I am compelled to be serious for a moment. This isn't very easy for me to say; in fact, these last few lines took much longer to write than everything else here. But here goes. My fellow graduates... Oh, I hear my beeper. Wouldn't you know it—gotta save another life. Good luck. □

A Soft Touch

by Harlan Krumholz '85



A few months ago I read some interesting news. It was about a new computer software package that can interview a patient, select from over 50,000 diagnoses, search a memory that contains all the recent issues of all the most important journals, and suggest the most appropriate treatment plan. What's more, the program is user friendly—and, by the way, never tired. I thought to myself that this is all very nice, but I just spent four years of my youth, \$60,000 of other people's money, and many sleepless nights in the hospital trying to ac-

quire many of these same skills. It made me wonder what we do that machines can't.

In some ways, we have just spent most of our time during the last four years acquiring skills that can be reproduced by a computer. We have created a data base. We have learned to classify information, to generate possible diagnoses, and to construct treatment plans. We have learned—at least we have done our best to learn—the facts of medicine. Important stuff. The way that molecules are put together. The mechanisms of drug interactions. The life cycles of various pathogens. The nuts and bolts of diagnosis and treatment. All important information for young doctors trying to keep pace with what was known yesterday—let alone with what will be known tomorrow.

The facts, however, do not completely capture the essence of the profession. Medicine has always been more than the mere sum of its scientific knowledge. There has also always been an art, although in this age the emphasis on technology increasingly overshadows the art. Is there still an art of medicine today, and what role does it play in the 1980s?



The profession is in great need of the art these days. Physicians are increasingly becoming cogs in a burgeoning medical-industrial complex. In addition, we are in danger of completely yielding to our technological triumphs. It often seems that we have become more adept at ordering tests and interpreting the latest technology than we have at listening to and examining our patients. It is becoming possible to diagnose a patient at a distance. In addition, we increasingly recognize patients by their diagnosis, identification number, and method of payment rather than by their name and personal characteristics.

Not only are patients losing their identities in this medical maze, we are losing ours. Patients are confronted by an array of different health care options. They are finding it more and more convenient to affiliate themselves with a place rather than a doctor:

"Who is your doctor, Mrs. Smith?"

"Harvard Community Health Plan."

"Who is your doctor, Mr. Jones?"

"The Health Stop on Massachusetts Avenue."

Patients and doctors are missing each other.

It's simple to say that the profession is in great need of the art these days, but it is much more difficult to define that art. I believe it has two basic underlying ideas. First is the notion that medical problems do not always yield to technological solutions. Emotions and values often play important roles in decisions involving patients. These factors cannot be easily included in a clinical algorithm, or combined with a laboratory result. They often play an important role in the onset, natural history, and response to treatment of a disease in ways that are not clearly defined in any textbook. Illnesses cannot be described in simple equations. Patients are not mere data points.

Our set of biomedical facts does not explain the constellation of reasons for which patients seek help and advice. Moreover, our biomedical expertise does not prepare us to ease the anxiety of a son whose father has been diagnosed with cancer, to console a pregnant adolescent, or to ex-

plain the meaning of "do not resuscitate" to a family anxiously waiting at its mother's bedside. When the facts are ambiguous or overshadowed by other factors, how do we proceed? How do we react to uncertainty? What words do we use? This is the art of medicine.

Second, there is the idea that physicians are like drugs—with potential for both therapeutic and adverse effects. The patient-doctor interaction can have a powerful effect on a patient's course. A smile, a word of encouragement, or a hint of hope can be a wonder drug. An unthinking remark or a gruff manner can cause more pain.

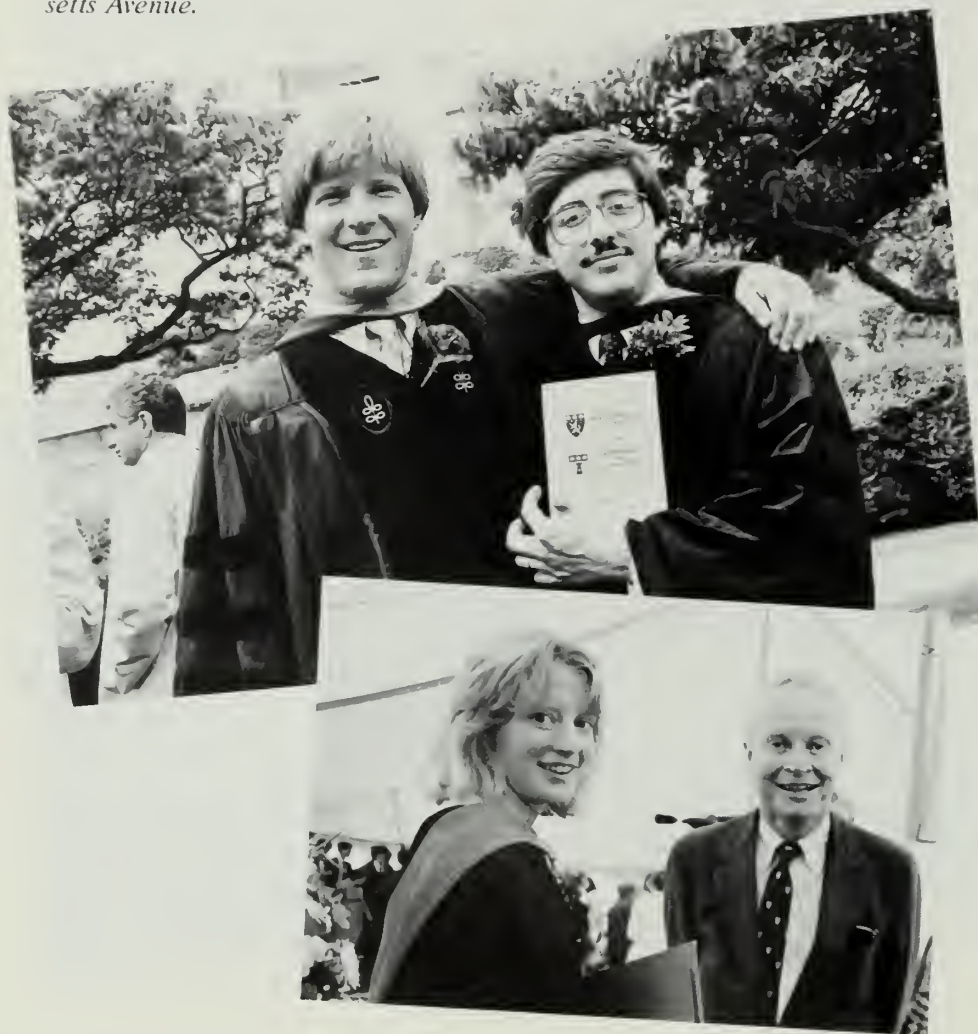
Caring makes a difference. This is the basis of the idea that medicine is more than just a job—the idea that it matters what happens to your patients, and that they are more than merely their diseases; that patients are people with feelings and families; that it is a privilege and a great source of satisfaction to be entrusted with the care of patients.

It's the art of this profession that I cherish. I admire the knowledge, but I cherish the art.

I've always thought that the difference between a good doctor and a bad doctor is knowledge, that minimum comprehension of the facts which differentiates someone who can help you from someone who cannot. But the difference between a good doctor and a great doctor is feeling—that comprehension of the art of medicine so essential in caring for a patient.

How can we retain and develop our skills in the art of medicine during these upcoming sleep-deprived years? How can we remember to have a soft, gentle touch with our patients? How can we remember to think about their perspective and how it must feel to be ill? How can we integrate the art and the science of medicine? All of us must find our own ways. I believe that one step toward that goal is through our patients' eyes. During an examination we all check the eyes for their size and reactivity to light, the character of the fundi, and the movement of the extraocular muscles; it's good for us to also check the eyes for loneliness and uncertainty, as well as confidence and strength.

In our quest to master the facts of medicine, we shouldn't forget to look in our patients' eyes—and, perhaps, through us and our students, the art can live through another generation of physicians. □



Ties That Bind

by Arnold N. Weinberg

I trust it won't offend that I identify myself as a fellow member of the Class of 1985. We did labor and learn together during each of these four precious years, bending over microscopes in microbiology, pontificating in pathophysiology exercises, caring for patients during medical clerkships, and sleuthing our way through the maze to discover the causes of obscure fevers in infectious disease electives. Curriculum adjustments have moved microbiology to the second year, and I won't ever be able to claim membership, with credentials, in future classes. Therefore, I would like to consider this a personal milestone.

It has also been my privilege to share lighter moments with you, when the full scope of your diversified talents and good humor illumed spectacles like your second-year show. I consider myself fortunate to have gotten to know many of you individually, and I speak for all your mentors and friends who share pleasure in your success.

Ties that bind. What does Weinberg intend to do with that subject? Perhaps Dean Tosteson envisions an appeal for heightened alumni involvement; the Alumni Office hopes there's a pitch to proud young physicians to sport *veritas* symbols on maroon kerchiefs and neckware; and parents of the graduates hope I will extoll the virtues of loyalties that unite daughters and sons, "the doctors," to their families. I'm confident that the Class of 1985 recognizes the metaphor, although among you some might accuse me of leaving out the "I" from "ties that blind."



*Ties attract interest, like
the plumage of some
birds. They startle,
indicate eating
preferences and habits,
display hobbies, teach
basic science, and
reflect one's mood.*

There are two themes I want to pursue that derive from my title. One has to do with the power of non-verbal communication, the other with the sustaining and inspiring impact of shared experiences among faculty and students that will be an influence long after you leave Harvard Medical School.

Each of us develops a style of non-verbal symbolic and physical communication as we interact with other humans. Babies respond to carrying and sleeping positions, types of motion, ways of touching. Societies often reveal status, educational achievements, group affiliations, peaceful or hostile moods in dress, gait, and gestures. We all project clues about ourselves, and we all receive messages from others through these powerful symbols. While discussing lecturing styles at a Boylston Society teaching gig in 1973, that quintessential communicator Elio Raviola said it very well: "... like facial expressions or gait, communicating with a large audience belongs to the sphere of the instinctive mechanisms."

In the teaching of large groups, which we have a surfeit of at HMS, physical activity is probably the most compelling non-verbal communicator. My colleagues will recall Alan Schiller's antics. A broad smile, eye contact, and what one does with one's legs are not too useful in a large amphitheater. Some individuals make strong statements with physical characteristics like hairstyles. Quite early in my professional career, I decided that ties would be the symbol that projected something about me, even when my Brooklyn-nurtured voice was temporarily silent. Ties attract interest, like the plumage of some birds. They startle, indicate eating preferences and habits, display hobbies, teach basic science, and reflect one's mood.

I'd like to briefly share with you some personal comments about ties, and leave for your own reading the

fascinating history of their invention and use.

Each of us appreciates that many of our habits and characteristics, as well as character, were molded and influenced in the family setting. My dad was a businessman who wore ties, but unfortunately he died of a staphylococcal infection when I was too young to notice or to need so formal an article of clothing. My mother made decorative hats for ladies. She counseled my older brother and me that dressing properly included wearing a tasteful unique adornment, like a tie.

During the early days of my residency training, I made the conscious decision that ties would be part of my dress code, a silent opening statement. The all-white uniforms of those days conveyed a rather cold and sterile sense that could be an instant barrier in dealing with patients. I instinctively moved to bright ties, quickly discovering that bow ties provided distinct advantages over standard cravats. They were closer to the face, so they could support a hopeful smile, and didn't stray when one bent over to examine a patient or inspect the contents of a bedpan.

The bright tie or other adornment can't substitute for the conveyance of caring in our facial expressions, eye contact, empathic gesturing, and the host of other non-verbal and verbal symbols of human interactions. It often, however, serves as an opener for conversation, and conveys a spirit of informality and warmth. We've all had different experiences; each of us must recognize those characteristics in ourselves, and in others, that facilitate or impede trust and confidence early in relationships.

Those of us who have worked closely with you during these years of your medical education have gained many intellectual and emotional rewards from that association. Those ties are sustaining and lasting. I firmly believe that the involvement of basic and clinical faculty in planning and teaching medical students, as is current in pathophysiology courses, and planned for in the New Pathway, can enhance the entire educational process. Perspective, relevance, and the admixture of faculty experiences provide a vital continuity. The patient becomes the focal point, the hub of the entire educational process, not just that part that follows preclinical courses. Like the

spokes and rim of a wheel, the involvement of all the parts makes progress possible even when the path is rough.

My relationship with the Department of Microbiology and Molecular Genetics over the past 20 years convinces me that this symbiosis enriches the educational process for students and faculty. The presence of clinicians in preclinical courses, even prior to students' direct patient experience, can make the ties between basic and clinical science direct and strong.

In the next stage of your continuing education, friends and familiar associations will take a back seat to urgent and anxiety-filled imperatives; it isn't any different for you than it was for me in 1956. I know that each of you is prepared as a caring and thoughtful person to interact with other human beings. Each of you had a unique set of experiences, interests, and goals when you arrived at HMS.

Your paths through these four years have taken different turns. Individuals from the Class of 1985 will contribute to society in a variety of ways in the future, but for now the focus will clearly be at the bedside, which, as William Osler said, is the

focus of a medical education. Clinical medicine is really taught, and patients are really helped. In various admixtures, most of you will care for patients and teach; some will pursue careers in medical science and basic science; and perhaps a few will break away and make contributions in non-medical spheres—perhaps even in politics.

I can say with confidence and conviction that each of you is more than equal to the responsibilities you're about to shoulder. This isn't the time when grades, lists of facts, research prowess, or publications count. This is the time when your energy, your honesty, your spirit, and your humane instincts—the collective character of your past and present values and experience—will bring caring and comfort to your patients and their families, wisdom and knowledge to yourself, and set in motion for the future "ties that bind." □

Arnold Weinberg '56 is professor of medicine, consultant in infectious disease to the University Health Service, and a member of the Board of Advisors to HMS.



Values and Professions

by Paul Tsongas

I was somewhat concerned by my invitation to speak today. I've been in public life for 15 years, 10 of which were in Washington in the Congress and the Senate, and I never was invited to a medical school commencement. This year I've been invited to more medical school commencements than I could speak to. So I asked myself why. If they were really interested in the wisdom collected in my brain cells, they would have invited me five years ago. I thought: no, what they're interested in are my aberrant lymph nodes. One of my partners said, "That's a cynic's view of the world; these are not students; they're doctors—and what they want to hear about are tax shelters."

Twenty-seven years ago I graduated from high school, and I have no recollection of who spoke that day. Twenty-three years ago I graduated from college, and again, I have no idea who spoke at my commencement. Eighteen years ago I graduated from law school, and, since that was the mid '60s, I did not go to my commencement. Thus, by definition, I have no idea who spoke there either. And so I have a sense that I will be the great trivia question at your reunion: who was that commencement speaker, anyway?

Giving commencement speeches is something I've gotten used to over the years, yet my invitation here really makes me wonder. In fact, I got more invitations this year than any year in my entire career. Why? I am out of politics. I've given up the power of the Senate; I am simply a private lawyer. I live in a small city in Massachusetts. Why would anyone want to



Many people believe I left the Senate for health reasons. That's sheer nonsense. I quit because I found other priorities. As a friend wrote me, no one on the deathbed ever said, "I wish I had spent more time on my business."

read yesterday's newspaper?

You are the elite—and there are countless public officials in Washington, or Boston, or anywhere, who would have gladly accepted this invitation. This is a very desirable audience for anyone in public life. The list of graduates and parents would be on any official's contributors list

by tomorrow. So why invite a former public official? My response to all of this has been to look inward, to look at myself. Nothing I did in Washington really does answer that question. I think the answer comes in my decision to walk away from the United States Senate. In doing that, I responded to a part of me that had heretofore been disregarded.

My family and I were certain about the decision, though we did it on two assumptions: that it was deeply personal, and that it was relevant to no one but ourselves. The first assumption was correct: the decision was deeply personal. The second was not. The decision spoke in a strange way to larger issues that face everyone in this society. There is something amiss out there in professionalism.

For those of you who have no idea what I'm referring to, let me give you a little history. By September of 1983, I had led a life that astonished all of my former college professors. It had included the Peace Corps, Yale Law School, foreign politics, Congress, the Senate. As my Harvard-educated father once said, "If you had only been a Republican, it would have been perfect."

Entrance to the United States Senate is conditional upon one's belief that your future's not the Senate, it is at 1600 Pennsylvania Avenue. Ninety-nine others in the Senate believe it, why should not I? To be elected to the Senate in one's 30s and never having been indicted is to cause legions of people to whisper such pos-

sibilities—not indictment, but the White House—in your ear all the time. Not bad for someone whose attendance at Yale Law School is still a matter of dispute to some of my classmates.

In September of 1983, I discovered a lump in my groin that turned out to be lymphoma, which is a mild form of cancer. It was not deemed necessary to take any kind of treatment for it for a year and a half, and the current treatment is quite inoffensive. Although the medical prognosis is rather optimistic, it is still in doubt. My future relies upon advances in medical research that simply weren't known two or three years ago.

In these 20-plus months, I have functioned normally and I have been as busy as anyone in my profession. The cancer, however, has had a different effect. It forced a hard look at values, at priorities; it took a sense of mortality, sat it across the table from me, and had it engage me in conversation. Life is finite. What an original thought. Not only my life and that of your parents, but yours, too. Do you believe that? Well, as medical students, you obviously do. But I mean really feel it in your own sense. For me, that fundamental realization took hold after the crude shock.

I was only 42 years old, with the world in front of me. What followed was a period of fear, then calmer acceptance of the fact that there was rational basis for hope. But as fear gave way to hope, the initial lesson had to remain and I will never forget, and don't want to forget, that basic lesson. Three months later, I was running for re-election, raising money, knocking on doors, and shaking hands at factory gates. A week later I quit. I quit because of the lesson that there are other values, other priorities, other things in life that are worth pursuing.

Many people still believe I left the Senate for health reasons. That is sheer nonsense. The United States Senate is a marvelous place to be if you're sick. There are insurance programs that you couldn't even think about in normal life, and with my re-election I would have been guaranteed six years of full-paid employment. What could be better than that?

The issue is not health. The issue is one's life and totality, and how it all adds up. As a friend wrote me, no one on the deathbed ever said, "I wish I had spent more time on my business." After 10 years of long hours—long even by doctors' stan-



dards—working Capitol Hill and running around the country, the state, the world, I had achieved professional success by any rational definition. But at what price? My wife had postponed her law education for my career, our children saw their father more than most Congressional children, but there were endless goodbyes and endless conversations that ended with, "I'll see you all in three days." My life had become one-dimensional and totally consumed with politics and its issues and its power and its prerogatives.

It's been a year now, and we have no regrets whatsoever. My wife is back in law school (a much better student than I was), my children are flourishing in the environment of Massachusetts, and, like all lawyers, I make far more money than I should.

But what's the point? Should I have not gone into politics? Not at all. Should I have opted out for a farm in Vermont? Hell, no, I would have gone stir crazy. And if I had, you would not have invited me here this afternoon. The point is not to avoid success. I'm very proud of my 15 years in public life. I think I left behind a record my children can be proud of. The point is balance. The point is perspective. The point is recognizing that there are other values that can be pursued, and have to be pursued, if life is to be whole.

I have three basic feelings about the medical profession. The first is that yours is indeed a noble profession. You don't have to get up every morning and wonder about the worth of what you do, and that is incredibly valuable. The self-doubt simply will not be there.

The second is somewhat different, and I'm going to illustrate it with two stories. Early in the 1960s, I was with the Peace Corps in a small village in Ethiopia. One day, after about a year, one of my students was absent from school. The other students told me he was sick. So after school I went over to the hut where he lived. He had a fever, and was very uncomfortable. I spent some time with him, didn't know what to do, and left to do other things as a teacher. Two days later he died, never having had access to medical attention during that period of time.

The next story: in my second year in Ethiopia, I had an American football sent to me. I tried to show a 12-year-old Ethiopian boy what you do with it. I said, "All right, Petros, you have to get from the goal where you are to the goal behind me. Run, and I'm going to try to stop you." He ran towards me, I tackled him, and I broke his collar bone. We rushed him into the capital city, where his collar bone was set. Two days later, one of the students came up to me and said,

"Sir, Petros is dying." You can imagine, as I was the one who had tackled him, how I felt.

I ran down to where he lived. Surrounding the hut were all these women in black chanting, "Petros yamal, Petros yamal," (Petros is dying). I ran in, and there was Petros lying on a cot saying, "I am dying, I am dying."

I said, "Petros, what's wrong with you?"

He said, "Sir, I am dying." I looked him over as best I could, and it seemed to me that the break had been set, and that there was nothing wrong with him. My diagnosis was that the women outside had convinced him that he was dying. So I ran back to the house we lived in and brought back medicine that in American terms would be called M&Ms. I said, "Petros, this is special American medicine, the latest advance of medical research in my country. It will cure your problem. Take two and call me in the morning." Petros took two M&Ms that day, two the next day, and the third day was back in class. Not bad for someone who never went to medical school.

The point is this: when I turned on the television this year and watched young Ethiopians dying, I remembered. I remembered the boy who had died. Young boys died this year in Ethiopia because no one was there with the skills that you have. The point is simply that if you leave here and go to suburbia and expend all your skills on those who really could go anywhere, and spend none of your life on those who desperately need you, you will have my respect but not my admiration. If you can't find two years of your life to give to those who need you, then you really haven't learned very much in medical school.

My final thought is this: to be a physician is to have respect, is to have the community value you—but what good are the respect and honor if you never use them? There are many who say that everything is fine, which reminds me of the farmer who was in an automobile accident; he sued the other side for damages, and it came to trial. The farmer was on the stand, and the attorney said, "Look, at the time of the accident a state trooper arrived on the scene and you said to him, 'I feel fine.' Did you say that?"

The farmer said, "Well, yes I did." "Well," the attorney said, "then how can you sue for damages?"

"Look," the farmer said, "I'm driving down the road in my pickup with a cow in the back of my truck. Your

client came across the centerstrip, hit me broadside, and both my cow and I went flying to the side of the road, badly hurt. The state trooper arrived on the scene, looked at my cow, said, 'This cow is in terrible shape,' took out his revolver, and bang, shot him right between the eyes. He said to me, 'And how do you feel?' I said, 'I feel fine.'"

Well, everything is not fine, and you are indeed the elite. You may not like that term, but graduation from this medical school puts you in that category. You have enormous God-given talent, and I think it's up to you to use it. I have every confidence that you will.

In closing, one final thought. When I left the Senate, I was astonished at how much power I gave up. I could look at my three daughters when I was in the Senate and know that I could affect their lives, affect the influences that would change their directions and give them a chance of survival. I don't have that now, and the irony is that I'm speaking to you.

You're the ones with the power to provide a world in which my children can grow up and do well. That is a noble task, and I wish you would do it well. □

Paul Tsongas is now an attorney with Foley, Hoag, and Eliot in Boston.





Alumni Day

The key word of Alumni Day 1985 was "change," starting with the changes the speakers had witnessed in medical practice and administration since their medical school years. Included in the addresses were Roger Bulger's plea that we determine our values and defend them in the face of rapid change; Donald Gair's observations on the metamorphosis of "patients" into "clients"; Robert Replogle's survey of disillusionment and hope among his classmates at the growing cost-consciousness in medicine; David Segel's reflections on the turbulent times through which he and his classmates have lived and worked; and Walden

Whitehill's memories of a career that has taken him from Hong Kong to prison medicine to the Indian Health Service. Adaptations of those addresses appear in the following pages.

There were the changes outlined by Dean Tosteson in his update on the state of the school. The most immediate is this fall's inauguration of the New Pathway, a new curriculum for 24 entering students. "We are undertaking this effort not because we think we have been a failure in the past," said Tosteson. "Rather, we think the pace of change in medicine requires a constant rethinking of how we prepare individuals to enter into our profession. Our New Pathway will have as its first, visible step a new



Incoming and outgoing presidents of the Alumni Council in what Clem Hiebert (right) called the "sweet act of remembering Kay Clawson" (left). The gift is a mirror from Shreves with a picture of Building A.

academic society, the Oliver Wendell Holmes Society." Out of the 165 students admitted this fall, 72 indicated their preference to enter the new program. From that group 24 were selected by lot. For more on the New Pathway, see the Winter 1984 *Bulletin*.

Among other innovations Tosteson reported were the recent acquisition of four floors of the new Biosciences Research Building (located across Shattuck Street from the Laboratory of Human Reproduction and Reproductive Biology) to provide new quarters for the Department of Genetics; plans for a new teaching facility behind Building E, to become "the

focus for the undergraduate medical activities of the institution"; and a major five-year capital campaign for HMS, to be formally announced in 1986.

For the Alumni Council and related bodies, noted Tosteson, it had been "a year of transition." There was the change of director of alumni relations from Perry Culver to Will Cochran ("You can't really follow after someone like Perry Culver," said Cochran in brief remarks before the

crowd. "You sort of come along in the wake of this cyclone. I find this is a blessing because there's a lot of momentum."), and the usual turn-over of president of the Alumni Council, this year from Kay Clawson to Clem Hiebert (see Alumni Council column in this issue). After an extensive search, Joe Murray has become the new chairman of the Alumni Fund. He had taken the reins as acting chairman when Carl Walter stepped down last year. The fund experienced a banner year, Murray reported, with a 33 percent growth in alumni contributions. Alumni Day moderator Joe Barr presented a Class of 1960 gift to Dean Tosteson of "slightly over \$40,000 and still growing."

Then there were, of course, features of the day that, to the editorial eye, never change—the sort that are unscheduled, created by the participants on the spur of the moment. The liberal dose of photographs in these pages attests to those events. □



From the 60th reunion class, Harry Savitz '25



The Veritas Imperative

by Roger J. Bulger

WHEN I RECEIVED THE CALL from my classmate Dick Kingsbury asking if I would prepare this address, I was reminded of the words of a young college professor—one of our favorites—who told us, “Harvard expects more of you, or makes you expect more of yourself, than you can possibly produce.” Dick followed in that tradition. He said I should be hysterically funny, authoritatively substantive, and mildly autobiographical—and that I should strike a delicate balance among the visions, values, and traditions of the past as I tell you how to move forward into the future. Failing any or all of these requirements, he said, I should be brief!

Without being overly autobiographical, I thought I would pick out a few selected ideas and perceptions I had a quarter of a century ago—to consider them now, and to think about their potential future significance.

Item 1. As a college student, I worked one year at Alumni Week. I saw, to my embarrassment, some real “old folks” behaving like college kids, trying to recreate their past. I said to myself, “I’m never going to do that. I’m going to live my life according to the prescriptions that my age and society lay upon me, and I’m going to play the role straight.” I had no particular idea what roles were appropriate for age 50 that were or were not appropriate for age 25—but I did think that idealism is the private preserve of the young, and that when you get older what you like is the way it is now, or better yet, the way it was 10 or 15 years ago.

Item 2. I can still see in my mind’s eye the “Veritas” sign over the gateway when I first entered Harvard Yard, and I must say it meant something to me. As an undergraduate and as a medical student, I found it incontrovertible and incontestable, a powerful mission statement that demanded its silken accountability from all who accepted the challenge and believed in the mission—and that, I presumed, was everybody. I certainly



believed in the integrity of my classmates; we shared the values of truth-seeking and truth-speaking to such an extent that we didn’t even have to talk about it.

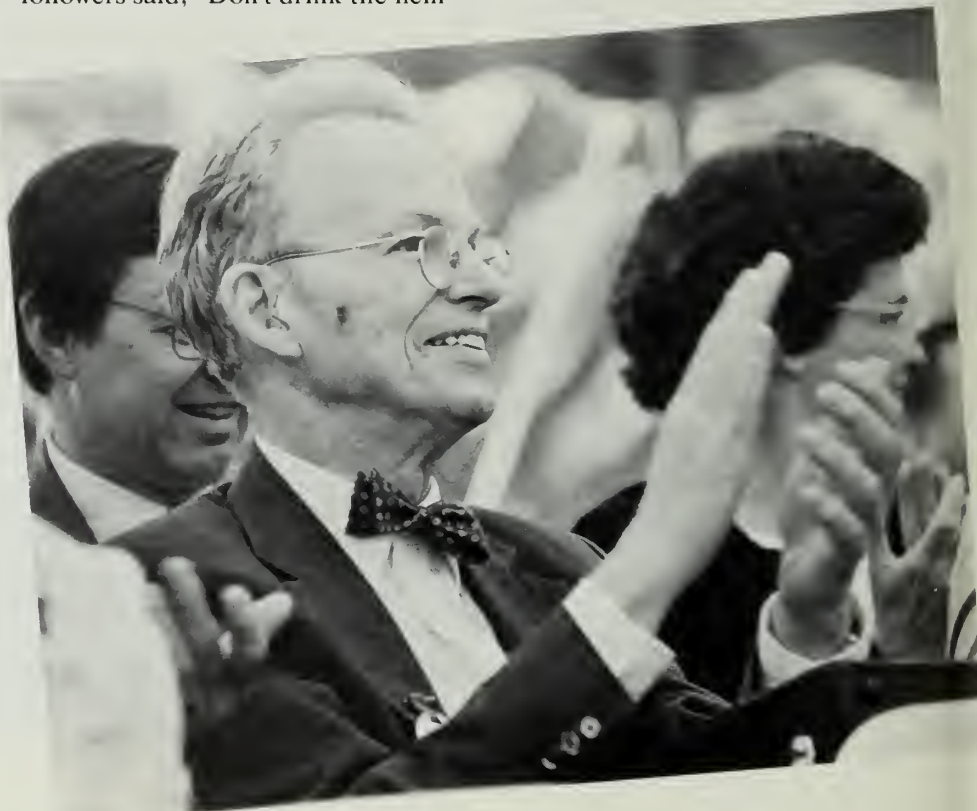
Item 3. In Philosophy 1A I read but didn’t fully comprehend the account of the death of Socrates, which described that hemlock-drinking episode as the key to his sustained commitment to the truth. Remember, his followers said, “Don’t drink the hem-

lock. Come with us, you can get out of it.”

“No thanks,” he answered. “I would be giving up the meaning of my whole life, because I’ve said—as I wandered around without any job or any status, just asking questions—that I would live up to the requirements of being a citizen of Athens. My fellow Athenians played the game right. They put me on trial; I lost; this is what I’m supposed to do.”

And he did it. I romantically thought, “Go on out to the mountains; go somewhere else, Socrates.” I guess I didn’t fully realize then that all of us who steadfastly seek the truth—in our daily life, our science, and our professions—also drink from a figurative cup of hemlock from time to time, even if in non-lethal amounts.

Item 4. Also in my very first weeks as a college freshman, I began a course taught by professor Sam Beer. He mostly focused on Max Weber and his concepts of the roots of modern Western democratic society fundamentally rising out of science and technology, the rationalization of the fruits of science and technology as our society evolved, and the ultimate bureaucratization that that was going to entail. There were also Weber’s ideas about the visions, ideas, and sentiments that give direction to institutions and societies. To tell the truth, I found the reading turgid and complicated, and the ideas uninteresting. I dropped the course, and I



wish I hadn't, because it might have prepared me earlier and better for the challenges that now confront us and our profession.

Item 5. I became a history major for a year, and was taught something that at the time I didn't believe was true: history cannot be written by the participants while it's going on. You cannot fully appreciate what's happening to you. An accurate history requires perspective, multiple observers, and certainly much careful analysis.

Item 6. As a medical student, I felt secure that the doctor-patient interaction was the unquestioned heart and soul of medicine. The Blumgarts, Castles, Leafes, Moores, Janeways, Grosses, Churchills, and Dunphys all made it seem so certain that there would always be room for the competent and caring physician, and that we could all be sure of the status of the physician-healer in our society.

Item 7. I was also certain of the role of science and of the integrity of the system. Cheating was a random event, an example of individual venality, and had nothing to do with the way we were organized in society or in academics, or the way science was managed. We believed in our politicians and statesmen, more or less, and in the essential integrity of our government. And we believed in each other.

Item 8. Some years later, when I decided to spend more time working with larger groups of people and maybe with institutions, I sought to become, according to the idiom of the time, a "change agent."

What has happened in the last 25 years? I think change has happened to us, change at such an accelerating pace that what once made us collapse in a heap goes on almost every week. For a while we became convinced that the rate of change would be too stressful, would be bad for our health, would in effect kill us.

We have focused on that problem and, in typical American fashion, have smashed it. We have analyzed change, learned to cope with it, spent our time immunizing ourselves to it. In so doing, we may get to the point, as I catch myself doing from time to time, of a sort of leaden acceptance of whatever some journalist says are the latest trends that will inevitably produce a future over which we have no control, in which we cannot participate, and to which we just have to

adapt. That makes for an awfully passive sort of citizen.

It's as though we no longer have the verve to attempt to shape our destiny; rather it seems enough of a challenge to endure or survive our future, which other people and other forces will create and shape. We have forgotten that a journalist, no matter how thoughtful or accurate, is not a historian.

One would think that we would have a greater sense of history—because so much happens in such a short time that events are telescoped—and that we would appreciate that terribly important, stable, and unsailable values and institutions can very quickly become assailable, unstable, and finally unimportant, if not non-existent. It occurs to me that it may be more crucial nowadays to know what we want to preserve than to know what we want to change.

Noted Viennese psychiatrist Viktor Frankl approaches the health of the individual by asserting that each person needs a meaning to his or her life that transcends pure self-interest, and that one should live in a way that attempts to change the world according to that meaning, whatever it is. If in a given situation one cannot change for the better, then one must rise above the situation. It seems to me that the prescription is the same for institutions, professions, and societies.

It's clear—we all know it—that science is being challenged at every point along the spectrum. The recent book by Broad and Wade, *Betrayers of the Truth: Fraud and Deceit in the Halls of Science*, lays out several examples of fraud past and present, and explores the environment in which they occur. The authors discuss how easy it is for supposedly critical people to believe an illusion, and the all-too-human tendency of scientists to be close-minded. They identify processes that seem to incorporate just the opposite of truth-speaking into the process of doing science. It is sometimes easier, they point out, to publish fallacious material than the truly important and creative discovery.

We are hearing from virtually every side that lying, fraud, and dishonesty are on the upswing throughout society. Misrepresentation is the mode in advertising; we've come to expect it in our political life; few people expect an accurate rendition of complex situations in the media. In *Lying: Moral Choice in Public and*

Private Life and Secrets: On the Ethics of Concealment and Revelation, Sissela Bok (whose husband is also gainfully employed) presents a convincing argument that relationships depend upon trust, which in turn depends upon an assumption of veracity. Without this trust, a democratic society is weakened and will ultimately crumble, and a personal relationship will likewise surely founder. She worries that deception and secrecy are destroying us. In such an environment it is not surprising that the citizenry would take any opportunity to consider scientists as dishonest, and to develop a loss of public trust in the scientific enterprise.

Not everybody agrees with Bok. Scholar Paul Elkman recently published a book titled *Telling Lies: Clues to Deceit in the Marketplace, Politics, and Marriage*. If you read the book, you can figure out who's lying. He writes: "Lying is such a central characteristic of life that better understanding of it is relevant to almost all human affairs. Some might shudder at that statement, because they view lying as reprehensible. I do not share that view."

Elkman quotes George Steiner, another scholar: "The relevant framework is not one of morality, but of survival. At every level, from brute camouflage to poetic vision, the linguistic capacity to conceal, misinform, leave ambiguous, hypothesize, invent is indispensable to the equilibrium of human consciousness and to the development of man in society. . . ." In other words, as I read this view, not only is lying prevalent, but it's good for the individual and for society.

In Richard Suttmeier's recent



cross-cultural analysis of fraud and deceit in China, "Corruption in Science: The Chinese Case" (published in *Science, Technology and Human Values*), he concludes that both the societal forces and the individual reactions—the guilt of an individual person—are at fault. If one accepts this idea, efforts to improve the situation must include attempts to improve the systemic factors as well as efforts to shore up the individual's moral structure and commitment.

It must be a little bit like Socrates drinking of the cup when a scientist withholds publication pending rechecking of a key experiment, only to be beaten into print by someone who started later and might have been less careful. Or when a reviewer for a journal reads a competitor's article and refrains from niggling criticisms that will hold up its publication. Or, in a study section at NIH, when competitors encourage rather than discourage one another, as I'm sure it must be all too easy to do.

I believe it requires conscious work and moral effort to maintain honesty throughout one's entire scientific life. I know I do better some days than others. Robert Kuttner recently observed in a *Science* magazine article, "Fraud in Science," that most of the recent examples of fraud and deceit in biomedicine have been perpetrated by M.D.s rather than Ph.D.s. Five years ago a study by F. Sierles, I. Hendricks, and S. Circle published in the *Journal of Medical Education* revealed that 58 percent of medical students admitted to cheating during medical school. This statistic suggests that educators must give attention to both curricular and environmental matters.

If we're not careful, there'll be an increasing bureaucratization of science, with elaborate systems for accountability which would institutionalize dishonesty and its sequelae. In other words, we will have made a bureaucratic game of cat and mouse out of what used to be, and I think should be, a matter of honor and personal pride.

What about medical practice and the so-called doomsday scenario? We all know it. Medicine and health care are being deregulated just as surely as the airline industry was, and the process is so deep and far-reaching that we won't be able to reverse it. It's being fueled, I think, by a surplus of physicians. The large companies with access to the hospitals, beds, and clinics will shortly be able to offer insur-



ance and prepaid care, capturing patients with better economic deals. Doctors will work for the companies and not for the patients; they may be afraid to criticize care inside the institutions because there will be two or three other doctors waiting in line, well prepared and well trained to take their jobs if the company decides it doesn't like the troublemaker who seems to be a patient advocate.

Now that kind of scenario is very sad. It can and may be written, but I don't think it necessarily has to be written.

There are values we don't want lost in any impending changes. Our job is to determine what those values are and to defend them. There is reason to worry about the future of the profession of medicine, of the role of doctor as healer, and, indeed, of the profession's capacity to continue to attract to its ranks the brightest, most highly motivated, most service-oriented of our youth. Will the "medical-industrial complex" defined by Arnold Relman of the *New England Journal of Medicine* destroy the physician as we know him or her by making the doctor an employee? Will deregulation of the health industry turn the physician from the role of healer to that of a technology-purveying, cost-conscious businessperson trying to provide the best compromise between quality of product and profit margin?

Will the continuing bureaucratization of our modern society, à la Max Weber, and its tendency to egalitarianism, mean that the effort is no longer viable to sustain an elite corps

of people with a special combination of talents and commitments?

On the other side of the coin, we've fashioned the best health care in the world. Isn't it conceivable that the fantastic technology of our computing and imaging age just might allow the physician more time to develop communication skills, and that a new rehumanization of health care could evolve? Isn't it possible that we could come through all this with what most of us hold dear about medical practice except some of our income and arguably many of the private, solo, general practitioners? These might be serious losses, but may not rank as true disasters for the profession.

As I go along, I am more and more impressed with the Oriental concept of a crisis as a threatening opportunity. Is the cup half-full or half-empty? For me, there is little appeal in yielding the mantle of idealist automatically to the young; in fact, it seems to me that it is our responsibility to work toward a clearer identification, again à la Max Weber, of the guiding, essential values and images which should direct our profession and institutions as they attempt to navigate the stormy and confusing seas of change, and as we seek to fill our half-full cup to the brim. Instead of "change agents," we should become "preservation agents"—not people who work against change, but people who work for it in the context of our core values. The nature of the doctor-patient relationship is one of these areas, and veritas—truth-seek-



ing and truth-speaking in science—forms another.

In closing, let me quote from Timothy S. Healy, president of Georgetown University, who recently spoke of the great virtues of a university that should not be cast aside as we go forward:

The first of these [virtues] is love of the truth, the secular, and not always only secular, equivalent of faith. To tell the truth day in and day out, stubbornly, even when it is not popular, is the very base of our community as a university. I pray that Georgetown will never lack men and women whose probity and love of truth can be transmitted to the young in such a way that when in turn their time of temptation or of suffering comes, the memory of it will put steel in their souls and hold them to the truth even if all the world comes tumbling down about their ears.

Even that superb statement says only a part of the truth that lies within the word, our word, "veritas."

In closing, I need to be truthful with you, because several people have asked, "How in the world did you get into administration?" I will answer with a true story.

In my second year of residency I came to Harborview Hospital in Seattle, Washington, where elderly and poor people struggle to get into the hospital. Those who got in were very sick; the hospital was crowded; the mortality rate was high. Robert Petersdorf was the head of medicine and I was the new resident on the block. A friend who had preceded

me on the service took me around and introduced me to 40 patients, many of whom I didn't realize were sitting on the brink of eternity. He said, "I have two of the best interns I've ever had, two of the best students. We haven't had one death the entire month; they've occurred in all the other services; we're going to have a great time."

I went to a prayer meeting the next morning with Dr. Petersdorf, and I had to tell him that during the night one of my patients had died. None of the other residents announced any deaths. The second morning two of

my patients had died, and none of the other residents had any. The third morning one of my patients died, and none of the other residents had any; and on the fourth day four of my patients died and none of the other residents reported any. Dr. Petersdorf asked the chief resident to go up on the wards and check on me. I went up and checked on the interns, and the interns were checking on the students, and the patients were trying to transfer. The next day we had one death; nobody else had any. And the sixth day I had two deaths to report and nobody else had any. And that was a Saturday.

When I went home my wife said "You're depressed; let's go out to dinner." I love Italian food, so we went to a Chinese restaurant. In that restaurant, right in the shadow of the Harborview Hospital, we had a meal. We were in there for 45 minutes and nobody in the restaurant died. We got to the very end, and—this is the truth, and this is my wish for you, and it changed my luck for the rest of that month and it's why I'm an administrator—I opened up that fortune cookie and it said, "Success in all your undertakings." □

Roger Bulger is president of University of Texas Health Science Center at Houston, professor of medicine at University of Texas School of Medicine at Houston, and professor of public health at University of Texas School of Public Health at Houston.

30th Reunion

Most came—the men, the few women.

We embraced with relief for having recognized the other: grayed heads, lined faces, and the women always seeming older (except of course the second, younger wives).

"You look the same, you look so well, so young."

The mirror of friends' eyes reflecting bias—at least tonight they see me as I want to be, and I them, alive, warm, giving.

As the sound escalates with martinis and joy

there is no longer envy of professorial ranks or worldly goods—if we haven't yet been on African Safari, it will come—everything will happen because nothing that evening has changed, except that we see each other more warmly than we remember. We are collaborators in a fantasy. Almost forgotten are the missing ones and that some of us won't make it next time.

—Susanne E. Learmonth '52

The Metamorphosis of “Patient” into “Client”: A Morbid Mutation

by Donald S. Gair

IT IS OFTEN SAID BY OUR GENERATION of physicians that most of us would never get into medical school today. That’s certainly not true of our class, nor of others in the 1940s and early ‘50s. As you will recall, Reginald Fitz regularly attested in letters of recommendation that all Harvard medical students ranked in the upper third of their class. However, it took a while for us to learn about that. At the time we applied to this school, most of us knew we would never be admitted.

I think that’s the best attitude to have, and I certainly hope those accepted at all medical schools these days—especially Harvard and its neighbors in the foothills, if not at the very summit, of Olympus—will continue to feel that they, too, are lucky to get in. After all, how can anybody be good enough to get into God school? The problems arise when we become convinced that we are.

Thirty-nine years ago next fall, I came to this Quadrangle elated by my good fortune to have the chance to learn the specific cures that must exist for all ailments known to man, as well as all the reasons for each ailment. In the first day I had met enough classmates to become somewhat intimidated; there were merit scholars, Ph.D.s, and other scientific stars everywhere I turned. They already knew a lot. And I was behind before I started. I would have to drive myself at a maximum pace. But where to begin?

I asked if there was a library, and I was directed to the Warren Library on the second floor of Building A. I went eagerly to see just how much I would have to learn in the next four years. I was thunderstruck by the immensity of the stacks of bound volumes, journals, and thousands upon thousands of books. Had the Countway been in place at the time,



I’m sure I would have fled forever, right then. I had no doubt that every word would have to be committed to memory.

At the desk I asked for a suggestion as to where to begin. It wasn’t too difficult for the student serving as librarian to see that I was not very far along in my path toward the degree. He said first-year students should start at one of the preclinical libraries. More books? Apparently yes. Off I went to the anatomy library. My growing frenzy abated somewhat when I saw that this library was more modest, all on one floor. I busily studied the books on the shelf nearest to the door.

One title contained a familiar word; I had been a biology major, and I recognized “physiology.” I took that book to a table and opened it, relieved to know that I was at least beginning the gargantuan task that I could see lay ahead. The title was *The Physiology of the Elephant*. The introduction was full of enthusiasm, explaining that, until this work, the largest land mammal previously studied was the Percheron horse. I was readily convinced that comparative physiology must be a vital aid to medicine, and I was therefore most reas-

sured to learn of the progress of science from Percheron to elephant, but shared the author’s dismay and impatience that we had not yet gotten to the whale.

Well, onto the text proper: the vital signs. This book began with the problem of taking the temperature of the elephant. It turned out that simple application of methods in use with human patients were not practical. Thousands of thermometers were lost. As I got to this point the librarian announced that the library was closing in five minutes, so I read ahead feverishly. By closing time I had learned two procedures for determining, with relevant accuracy, the temperature of the elephant! I won’t bother to revive all of that for you here.

Not a bad beginning, I felt, for the day before classes officially started. But as I went back to Vanderbilt Hall I wondered if I hadn’t perhaps started a bit far afield with the elephant. I sought the wise council of Dick Butler, who had been through all this before. He looked troubled, and convinced me I’d best unwind by playing cribbage. That was at least one thing I knew well—though not, it turned out, as well as he. The game was followed by other unwindings: squash, basketball, and learning the lore, songs, and poems of our venerable institution.

Then classes began. No one can think about the first year at HMS in the magic years Bobby Green taught anatomy without the vivid memory of his remarkable presence. He was the ultimate physician and teacher. We were his last regular class. (I don’t know if we drove him to leave; I think he had planned to retire before then.) Anatomy is “all Greek” to many medical students, but those privileged to learn from Robert Montraville Green were taught in untranslated Greek and Latin, as well as in impeccable Brahmin English.

Classes followed classes and information flooded in; little was as clear as the first lesson I learned about the elephant. But there was something else I knew clearly: if I ever got through medical school and became a doctor, I would be treating patients. Whatever field we went into—from surgery to psychiatry to pediatrics—my classmates and I would be doctors and we would be treating patients. And that’s what we have done.

So it was.

So it still is in most areas where doctors and other healers work their

skills. But not in all.

Here in Massachusetts, in the Department of Mental Health, the generic word for those human beings who turn to, or are sent to, the various programs and facilities connected with maintaining or reconstructing mental health is no longer "patient," but "client."

This trend is not limited to Massachusetts, but it is primarily localized, as far as I'm aware, to the areas of responsibility in psychiatry that are shared by other disciplines, notably clinical psychology, social work, and psychiatric nursing (and that is not an exhaustive list).

This development has been going on for some time. I think it has its roots back in 1942, when Carl Rogers first wrote about "client-centered psychotherapy." But I became aware of the extent of it only in the last several years through enforced skimming of reams of official Department of Mental Health documents.

To the shrinking number of M.D.s working in DMH, this development has been disorienting and disheartening. There is little doubt that the emergence of the word "client" to replace "patient" has to do in part with a specific intent to demedicalize mental health. Part of this effort stems from interprofessional competition; part from honest belief that the concept of sickness begets disability, and that the word "patient" perpetuates patienthood. There are serious problems in this development—one of which is the global deprofessionalization of the care of the mentally ill.

I have chosen the topic of metamorphosis from patient into client for this 35th Reunion chat because I think it is relevant to all of medicine, not only to psychiatry.

IN MY SECOND YEAR OF PSYCHIATRIC residency, in 1952, I worked three nights a week (it wasn't called moonlighting then) taking emergency medical calls for Massachusetts Medical Society. This job took me around greater Boston at all hours of the nights I was on duty. Many of the patients I saw were on welfare. When I saw the first welfare form I had to fill out, I should have had a premonition of what was to come. Where my name was to go, the form did not designate me as "physician," but "vendor." I had previously noticed this word on a government document only on those licenses tacked to pushcarts on the streets of New York and Boston.

I recognized some relevance in the term. I was, after all, going to be paid for my services, and in that sense the government could regard me as having sold them. However, I was jarred then—and still am—by the concept that I had peddled those services. I was ultimately paid, by the way—not very much (I think it was \$3.00 a visit), and at an average wait of one-half year after each event.

I don't remember how the patient was identified on that welfare form; I was so rocked by my own characterization as a peddler that I didn't notice. But it must have been "client." The coupling is automatic: vendor/client, seller/customer: the marketplace.

Those who would eliminate the word "patient" from the official language of a major governmental health department do not do so because the word is simply outmoded. They do so because it is one of those words that implies its partner. It is a relationship word. The choice of "client" does not imply with any specificity at all what the partner in that relationship will be. "Patient" implies "doctor" or "nurse." It also implies sickness to be cured.

In systems theory, sociology, and family therapy approaches, "patienthood" is an almost accidental, and certainly not exclusive, possible manifestation of what is going on in the whole system. Another reason to abandon the term "patient" is its association with the mystique of sickness and cure. In the 1960s, when there were many rallying calls against

the establishment and against professions—in health, illness, education, government—one slogan was: "Health is too important to be left to the physicians."

In the egalitarian and anti-professional zeal to avoid elitism and excessive compartmentalization of humans by medical labeling and triage, there is a trend to avoid distinctions. The rationale has been that distinctions classify and discriminate—and discrimination cannot remain practical; it always becomes, in this logic, a basis for prejudging in harmful ways. If we use words that imply traditional relationships, this reasoning concludes, we enshrine traditional discriminations and prejudices. Think of some of the common relationship pairs: parent/child, teacher/pupil, minister/parishioner, lawyer/client, vendor/customer, salesperson/customer.

Proponents of the shift to non-specific classification of service relationships such as the client/vendor concept also see a subservience/dominance role relationship in the patient/doctor pair. There is some civil rights discomfort aroused by this idea. It is curious to note that the word "client" referred to relationships in Roman and Medieval times in which a client was subservient to a patron—at the beck and call of an influential person. The Latin root is *clere*, meaning to hear or listen. The current common synonym is "customer."

Back to the urge to avoid distinctions: It is easy to talk about a doctor/patient relationship, or a nurse/pa-



tient relationship. Those terms conjure up a picture that would be translated accurately in any language: a distressed-looking person whose pulse is being taken by a concerned-looking person, or Person A with mouth open and Person B with a tongue depressor. The words connote the distribution of problems, tasks, and intent. Even the client vendor pairing has some implications, including the notion that if a deal is not concluded, the provision of health specifics (or whatever the vendor is vending) will not transpire.

Some civil rights people have a related concern with the parent/child relationship. Some attorneys have gone beyond such issues as unfair civil commitment to institutions to children's right to decisions other than those of their parents about such matters as school, vacations, camps, and dentists. These people might well suggest that children be called the clients of parents and parents the vendors (although gratis) of parenting services that the children can take or leave as they (and their attorneys) see fit, and for which they can shop around and get the best deal. In fact,

the most common and longstanding professional relationship that includes "client" is that of lawyer/client. Perhaps the litigation role of many patients and their lawyers is another source of the trend toward use of "client."

MEDICINE ITSELF IS INVOLVED IN the drift toward commercialism. All around us, for years, medical school deans, hospital administrators, and heads of departments have had to compete for federal dollars, private grants, and bequests. Now we have HMOs and all the related aspects of the struggle for dominance in the health-care marketplace. And in the individual relationships there is also the concern, not always overblown, of the high income physicians traditionally have been thought to receive.

There is widespread need to cut costs and increase efficiency. Checklists and computer aids to diagnosis are proliferating; judgment is often elbowed aside as old-fashioned, a self-serving arbitrariness of physicians. Fit-

ting into this concept of cost-effectiveness and time and motion studies is the passion for contracting for services: customer, salesperson, contract, deal.

Forty or more years ago, Carl Binger '14 wrote a little book called *The Doctor's Job*, about psychological and emotional factors in medicine. He told an amusing story about a peculiar condition known as "paroxysmal lacrimation," often accompanied by downturned mouth, stooped shoulders—easily identified by those two pathonomic signs connected with all this water going down the cheeks. Many cases responded to high doses of atropine, but refractory instances required excision of the lacrimal glands.

Rather than seek out one's physician for help, one could ask for bids to service paroxysmal lacrimation; the low-bidding vendor would get the contract.

Clearly, labels simplify this process. You have to label what you're in the market for, and then set up bids. You may need a contract for incipi-



ent exsanguination, status epilepticus, and another that would be easily packaged: imminent auto-defenestration. Were the trend to continue, the degrees granted to our successors graduating from HMS would be M.V., *Medicinae Vendoris*. Hospitals would have emergency out-client wards as well as in-client services. Perhaps some generation might get used to that. Not ours.

I've briefly summarized the derivation of "client." The word "patient" has had the same meaning for millennia in all Romance languages, with equivalent words in every other language. "Patient" is derived from the Latin verb *pati*, meaning to suffer.

Everyone who is sick and hurting, who is suffering, endows the potential healer who comes to his or her side with a godlike quality of res-

cue which everyone recognizes is a substantial part of the comfort that ensues, if not of the cure. The worst consequence of this magical placebo effect is that it can encourage arrogance in the healer and mistaken belief in the specificity of "cures." But it is always a major factor.

Those who suffer call themselves patients and they seek healers, not vendors. We can change our system of providing services, our medical school curriculum, and methods of payment, but as long as doctors are part of the healing process, we will call our patients "patients," even if it becomes illegal. □

Donald S. Gair '50 is professor of psychiatry at Boston University, and chairman of the Department of Child Psychiatry.

Is 60 Minutes Enough? Are We Bottom-Liners?

by Robert L. Replogle

I HAD NOTHING TO SAY FOR THIS occasion, and hoped my classmates might come up with some pearls of wisdom, so I sent out a questionnaire. As I put it together, going through the yearbook and looking at names, I became intimate with this class. I began to have a lot of thoughts, and finally had a vision, which I'd like to share with you. It was of my classmate Dave Segal, many years hence, who had died and gone to the Doomsday Room to receive his judgment.

Dave sat down next to Robert Redford and Sean Connery. A voice over the loudspeaker said, "Sean Connery, report to Room 101." So Connery went to Room 101, opened the door, and there on the bed was a terrible-looking, unkempt, dirty woman. The voice said, "Sean Connery, for the sins and transgressions of your life on earth, you are sentenced to spend eternity with this woman."

The voice came on again and said,



"Robert Redford, report to Room 102." Redford went to Room 102, where there was another female, worse than the first. The voice said, "Robert Redford, for the sins and transgressions of your life on earth, you are sentenced to spend eternity with this woman."

Finally the voice said, "Dr. David

Segal, report to Room 103." So Dave went to Room 103, opened the door, and the room was empty. He went in, sat down, and the door closed. Finally the door opened again. Standing in the doorway was Bo Derek. David's eyes lit up. The voice said, "Bo Derek, for the sins and transgressions of your life on earth. . . ."

Twenty-five years ago. Before the Kennedy-Nixon debates. Vietnam had begun, but we didn't know it. No legionnaire's disease. No AIDS. No third- or fourth-generation cephalosporins. Few computers. No Title XIX. Plenty of idealism, at least in the Class of 1960. Plenty of optimism. There wasn't a thing we couldn't do, fix, resolve. I loved this class; I still do. I think we all feel the same way about one another. It's clear from your survey responses that the relationships we had for four years had great impact on our lives.

I have a lot of personal regrets. I didn't accomplish much. I lost my idealism, I lost touch with most of you, and I wish I had been able to stay closer. Never again will we be assembled like this, and it's unfortunate.

After school and the residency years I was getting the hang of what was going on, thinking the work was good. Then something happened that didn't seem like much at the time, but I see in retrospect may have been a turning point for me.

In May 1972, on "60 Minutes," Mike Wallace interviewed a woman in Akron, Ohio, who had a baby with a complex congenital heart problem. The father had been laid off. The family had lost its health insurance, and the mother said they could not afford to have the baby's heart fixed. She said, "If you don't have money in this country, you just die." I called CBS in New York, and I got the producer of "60 Minutes" on the phone. I said, "give me that family's address and phone number and I'll see that the baby gets her heart fixed."

The CBS people said, "No, we have a positive policy not to give out that kind of information. It would be demeaning to the family, and we cannot respond." I couldn't budge them.

So I called Jay Ankeny, chief of cardiac surgery at Western Reserve. I said, "Jay, what is going on in Cleveland? How could you be so cruel-hearted not to get that baby fixed?"

He said, "Are you crazy? That

baby was fixed four months ago. Cost never came up at any time. She was covered by Ohio Crippled Children's. The father had private insurance with his job, and he wanted to collect that insurance in order to have a little extra on the side."

So I called CBS back and said, "You lied! How could you do that!"

They said, "Doctor, we were trying to make the point that health-care costs are too high, and we made it." At that moment I began to wonder what in the world is going on.

As I worked my way through the academic committees at University of Chicago, it began to dawn on me that some of the tenets that seemed so clear in school, in my association with you all, were not universally admired. Expedience, pettiness, and political maneuvering sometimes were part of the game. I suppose I should have been less naive.

During our sophomore year, when assistant professor of anatomy George Erikson left HMS to go to Brown, I had a bit of a puzzle. He was one of the most devoted teachers we had in our preclinical years. It was hard to understand why HMS would let him leave. Ten years later, his departure was no longer a mystery to me. There was little place in an academic department for someone who was "only" a teacher. At the time it did not occur to me that there was little room in a clinical academic department for someone who was "only" a doctor. It didn't really affect me, because I published enough to get tenure. I enjoyed the students and liked the lab; things were moving along fine for me in the great teaching, research, and patient-care triad.

Patient care was the easiest. We all learned what the doctor is supposed to do. We knew about Francis Peabody. We were impressed by Merrill Sosman diagnosing the rupture of his berry aneurysm while he was falling to the floor in the X-ray department of the Brigham. We took patient care seriously; we still do.

I interned at University of Minnesota with Phil Leder, who is now chairman of genetics at HMS, one of the best scientists. Phil, as far as I can tell, now speaks in tongues. I can't understand what he does—and I've tried. But I can say with first-hand experience that when Phil was at Minnesota he was a first-rate doctor.

When Phil was an intern, I remember, a young woman came in with respiratory problems, and was

being worked up. Phil heard a diastolic murmur, but none of the senior people heard it. He stuck to his guns, went back and reexamined the woman, exercised her, and heard it over and over again. Finally people agreed with him, the woman underwent cardiac catheterization, and they found she had left atrial myxoma.

I was struck by this case. I was grateful to Phil not only because I had the opportunity to see it, but because I was overwhelmed by his concept of what a doctor does. And let me tell you, when Phil went to NIH to work with a fellow named Marshall Nirenberg, I thought, "Medicine is losing a great doctor"—which it was. I'm only happy, I guess, that he's a great geneticist.

As we got better at our clinical work, the science improved, and we utilized it. We took no shortcuts; we wanted to do the very best, avoid mistakes, achieve perfection. The costs escalated. Perhaps we over-achieved; perhaps everybody wasn't just trying to do a good job, and some took advantage of the system, but it was all basically for a good cause. And then, suddenly, the cost-benefit analysts and bottom-line advocates came out of the woodwork. We had gone too far. We as doctors had to decide whether society could afford to offer complex cardiac surgery to a Down's baby; whether an elderly soul with a chronic disease was worth the expense of treatment.

I said, the hell with it. If the feds want to control medicine, if they want to ration it, they're going to have to take responsibility for it. I'm a doctor; my contract is to help sick people, and they can't make me do otherwise. I couldn't have been more in error. They not only have, they've produced a new industry just to help them.

Hence the title of this talk: "60 Minutes" (or how I found out there ain't no tooth fairy) and the "Bottom Line" (or how to decide who gets what). So I decided to find out whether my buddies were as bad off as I was. I can tell you that you are.

A few quotations from classmates:

"Teach: Don't be the first to join any given HMO, PPO, etc.

Maxim: The first Christians got the best lions."

"Would quit medicine if I could make a living in music."

"I feel impotent because of external changes over which I have no control."

"Medicine's tradition is glorious and may be sacrificed to society's cynicism and legal/accounting mentality."

Our disillusionment is deep.

Few of our offspring are in medicine, a change from prior generations. Even more striking, few of us are encouraging our children to pur-



sue medical careers. Many of you wondered if you had done the right thing by going into medicine in the first place. What a turn of events! HMS is entering an age of medicine when biochemistry, technology, and money are blending into the age of opportunity for doctors and patients. This should be the best of times. What happened? I don't know, but I'll make a few guesses.

The beginning of the change came about as a result of the efforts of well-meaning people to accomplish worthy objectives. An example is Title XIX, the objective of which was to provide good medical care for the elderly and indigent. I cannot imagine how it must have been for old people before 1965, depending on the charitable instincts of physicians and hospitals for their care if they couldn't afford to pay. I can remember well my father telling me about taking my grandfather to the doctor in the Depression years of the '30s. Neither of them had any money. The doctor treated my grandfather, but as they left the office the doctor said, "Next time, old man, bring some money." My father never got over the humiliation.

When the government began to pay the bills for everyone, the charitable instincts of doctors were slowly snuffed out. It became fashionable, even admirable, to talk about the health-care industry. Hospitals found that there was no end to growth; there

was a bottomless source of income. The incomes of doctors went up, and another parasitic group, the negligence lawyers, saw an opportunity to feed. Doctors got hooked on costly gadgets.

When you get more, you want more. For Boone Pickens it's a hobby—not particularly destructive, since the corporate executives he will displace have already fitted themselves out with golden parachutes. But Boone Pickens is not a doctor. For doctors, for the profession, this attitude was destructive. People came from all over the world to participate in the gold rush. American lawyers flew to Bhopal to stake out their claims in that gold mine; Indian physicians came to the United States for a better opportunity.

This is the profession of Osler, who said, "We are here to add what we can *to*, not to get what we can *from*, Life."

Big business. Profits. Marketing. Advertisements. How do you adapt the Hippocratic Oath or the Oath of Maimonides to the corporate mentality, the bottom line? How do we adjust to corporate marketing strategies that parade Bill Schroeder, Murray Haydon, and Jack Burcham—all recipients of "the artificial heart"—across the front pages of newspapers, the 10 o'clock news, and *People* magazine, to enhance the company logo? Health-care planners, helped along by waste propagated by slovenly, non-thinking doctors, determined that

health care was a luxury; it changed in five years from a basic right to a luxury. And we, as the transition generation, are confused, angry, and despondent. We thought we were doing good, and now everybody hates us.

So what do we do now? I suggest we return to our basic mission: helping sick people. The practice of medicine in a humanitarian way is the most blessed of opportunities. Amidst the despondency of your responses to my questionnaire, the one item with which you all uniformly agreed was that working with patients still gives you the most professional satisfaction. Let's grab the chance to stop thinking about money, prestige, power, and society memberships, and concentrate on doing what is right. If we take good care of our patients, we will be rewarded with great power.

Cromwell said to Bellaire, "No one rises so high as he who knows not whither he is going." I would paraphrase that, "No one is so powerful as he who does not care for power, money, or glory." Let us learn again, if we have forgotten, the invigorating satisfaction of doing something because it is the right thing to do. Let us treat our colleagues and patients with respect, honesty, interest, and compassion. We should refuse to bow to the grinding machinery of the medical industry; we serve patients, not corporations. We may—certainly will—suffer temporary losses, but no one here is going to the poorhouse. Over the long pull, we will emerge as a miracle—the first time a group has discarded apparent self-interest for real self-interest. The technological progress of the last 30 years has given us, for the first time in history, great power to help people. Let us not throw away the opportunity to use it by discarding the rock-solid foundation given to us by the great doctors and teachers of the past. *We* are the great doctors and teachers of the present; it is up to us to say, "Enough of this nonsense."

I cannot let the opportunity go by to thank the wonderful teachers, some here today, who gave us the chance to enjoy the life of a doctor. Some who spring to mind include William Castle, Walter Bauer, Guido Majno, Cliff Barger, Erik Ball, Jay Angevine ("neuroanatomy is fine with Angevine"), Russ Barnett, George Erikson, and Francis Moore. What made them special? Their depth of knowledge, to be sure, but also patience and willingness to spend time and effort on our behalf. We didn't





know it then, but some of them spent time with us that, for their own professional advancement, could better have been spent working on their own projects. For that, we belatedly thank them.

Since Dean Tosteson has the final word, it seems proper for us to tell him what was good and what was not important in our education, from the 25-year perspective.

No one in the Class of 1960 thought the architecture of the classroom was important. The likelihood that we would be better doctors or scientists if we had had the opportunity to be taught in a modern Taj Mahal of a classroom with a Henry Moore sculpture in the rotunda and Dali etchings on the walls seems remote. I must say, however, that we could not have done without the tennis court in Vanderbilt Hall.

The teachers are critical. Judah Folkman convinced me recently that Dean Tosteson is serious about considering teaching effort and ability when determining promotions. This is indeed revolutionary, and perhaps anxiety-provoking for those poor young souls who depend on grant support for child support. I think I would prefer the Jarvik 7 artificial heart to NIH support for my life-support system these days.

With regard to the teaching in the clinical years, our class with near unanimity recommends that clinical

teachers be required to practice medicine—and this recommendation is not meant simply to enrich the faculty practice plan. By “practice medicine” we do not mean a two-month rotation as a tourist on the “teaching” service, coming on the floors three days a week, gathering up the charts and the house staff and disappearing into a conference room to discuss interesting diseases.

Francis Peabody, in his article “The Care of the Patient,” had yet another marvelous observation: “The essence of the practice of medicine is that it is an intensely personal matter, and one of the chief differences between private practice and hospital practice is that the latter always tends to be impersonal. At first sight this may not appear to be a very vital point, but it is. As a matter of fact, it is the crux of the whole situation. The treatment of a *disease* may be entirely impersonal—the care of the patient must be completely personal.”

Osler put it yet another way: “The clinician should always be in the fighting line, and in close touch with the



rank and file, with the men behind the guns who are doing the real work of the profession.”

There is renewed vigor in medical education at Harvard. Witness the New Pathway. In the *Bulletin* issue that described the New Pathway, I made an important discovery, which I want to share with you. You all are aware of the branch of Kremlinology that predicts the new leaders by observing the locations of the Politburo members in the May Day parade: Gorbachev stands next to Brezhnev; obviously he will be the new chairman. I have adapted this technique to HMS, and am glad to announce that Phil Leder is destined to be the next dean. Take a look at the pictures in all the issues of the *Bulletin*, especially the New Pathway issue. Leder immediately to the right of Tosteson in every one. You heard it here first.

Back to the New Pathway. I was immediately cynical, but not about its educational value. We all can immediately grasp the value of an integrated curriculum, intensive faculty teaching, and so on, because we were the recipients of such an experiment in our second year. We had a marvelous integrated curriculum that year, but in another year or two it disappeared. Why? I can't say for sure, but almost 20 years of faculty experience at all levels gives me some insight. How do you motivate a faculty to overcome self-interest, developed to a fine razor edge by years of academic honing, to devote the hours required for outstanding teaching?

I am less cynical about the New Pathway today because I had the opportunity to talk with Judah Folkman last week, and he convinced me that it is a winner. As a matter of fact, I feel like going back and joining the Oliver Wendell Holmes Society for a refresher, except they wouldn't let anyone like me in anymore. I cannot help but believe that HMS will be all right: the students have one another. Looking around at classmates from whom I've learned so much and for whom I feel so deeply, I'd like to end with a quotation from two great Harvardians, Christopher Jencks and David Riesman, in *The Academic Revolution*:

A college's justification for almost all increases in its academic expenditure is the improvement of instruction. Spending more will mean wiser, happier, or more erudite alumni. Otherwise why waste the money? Such claims are, however, often quite hard to support. A college that seeks

to endow a new chair in Oriental history, for example, cannot easily show that students will learn more from studying the Ming Dynasty than they now do from studying Medieval England. (Indeed, the college often cannot even make the claim, lest the Medievalists become agitated.) In any case, concern for the students is seldom the compelling reason for seeking the chair. Rather, the college wants such a chair to enhance its academic reputation vis à vis other colleges, and to make local faculty feel their institution is "with it."

Yet the college is also a prisoner of its own rhetoric. If it spends more money than most of its rivals, those who are asked to pay cannot be candidly told that their money is simply to boost faculty morale. They must be told that the extra outlay brings better pedagogic results. To "prove" that this is so, the college must turn out more distinguished alumni than its rivals. One way to do this might be to enroll ordinary students and then make them distinguished by devoting extraordinary resources and skill to their education. But the outcome of such efforts is seldom sufficiently spectacular to impress potential financial supporters. It is therefore necessary to recruit students who are extraordinary to begin with. Such students then educate themselves and each other. The faculty need only lecture them occasionally, give them reading lists of edifying books, and set a reasonably good example as cultured, disciplined adults. Since able students enjoy kindred spirits, they develop a measure of loyalty to any college that is composed mainly of other able students. This loyalty usually survives even if the faculty is distant and dull. As alumni, these students become walking testimonials to their alma mater, both because of what they say directly about it and because of what their talents say indirectly about it. Their existence seems to justify both earlier expenditures and current pleas for more money.

There is no doubt that HMS is great—we all know that. But give me the classes of 1960 and 1935 and 1985, and perhaps we can reshape the world. Can we, by our combined efforts, put it all back together again? I suppose deep down I doubt it.

Perhaps those young people of the Class of 1985 will grab the baton, inspired by our efforts, to go back to the practice of medicine determined to do only what is best for the patient—not what is best for the hospital, the HMO, the PPO, or themselves. And that, dear classmates, may be enough. □

Robert L. Reptogle '60 is professor of surgery at University of Chicago School of Medicine and chief of cardiac surgery at Michael Reese Hospital.

An Overland Odyssey: From the Muddy to the Ohio River

by David P. Segel

ON A SUNNY JUNE AFTERNOON about 29 years ago, as I was walking toward Building D, I looked across the courtyard and saw the seniors preparing for Class Day. They looked so mature, so confident, as they stood around chatting quietly. I had a sharp sense at that time, near the end of my first year of medical school, that I would never acquire their evident assurance—that I might not even live to the fourth year.

Almost three years to the day from that episode, I was standing in front of Building C talking with friends and family. As class historian, I was somewhat anxiously awaiting the beginning of our own Class Day exercises, holding my speech, thinking that its slight heft belied the month's sweat that had gone into its composition. I glanced across the courtyard and saw two or three freshmen looking toward us. Their expressions betrayed emotions close to what my own had been three short years before. I was tempted to walk across the courtyard to share the moment with them. I wanted to reassure them that the time would pass quickly. I didn't move, however, and they soon picked up their pace and proceeded with their own thoughts to their last classes.

Each trip back to this courtyard in the spring—each walk over the grass—recalls for me those two mornings in the spring of my medical career. It is good to return in the late summer—or is it early fall?—of that career.

The most anxious period of my medical student days occurred early in the first year. Though I was comfortable with my decision to become a physician, my brain handled anatomy the way the kidney handles sulfate: filtered it freely but reabsorbed very little. By the evening before our first oral examination, I had become extremely anxious. As was my habit since undergraduate days, I had stud-



ied until midnight, figuring that I had done my part. If God was so perverse as to want to flunk me, well, that was his problem. I could always go into my father's clothing business. (If selling clothing turned out to be my fate, I wouldn't even have to give up contact with classmates and some of my professors. I recall that Steve Cohen bought clothes from my dad, as did Bob Holden.)

I digress. As I was trying to fall asleep the night before that infamous oral, a brisk wind blew up Longwood Avenue. I became aware that a street sign was rhythmically banging against its pole, its bottom bolt having come loose. Pulling on tennis sneakers and a pair of slacks and arming myself with a coat hanger, I descended to the street muttering and cursing, hoping that neither the police nor any of my classmates would see me and assume that my psyche had slipped its moorings. I shinned up the pole and secured the sign with my hanger. Since I wasn't used to shinning up poles, I exhausted myself in the effort, and was able to fall asleep knowing that someday I would have a mildly amusing story to tell.

Incidentally, things didn't go well the next day. Dr. Edwards asked me for the location of the plantaris muscle, and wouldn't take "in the bucket"



for an answer. I was finally to learn the location of that muscle 17 or so years later on a tennis court, when I ruptured it hitting a winning backhand volley.

As medical school progressed, more members of our class became certain of their future careers. Several required only confirmation that their preconceived career plans were realistic. A few, like Bob Repogle and Les Ottinger, were born surgeons and needed only to get through with medical school in order to proceed to the next phase of perfecting their craft. I'm not sure how many of you, like me, were able to decide only in senior year on your branch of medicine. Certain positive tropisms inclined me toward surgery, but there were a number of problems: a recurrent low-back condition making long hours in the O.R. unpleasant, difficulty reading the surgical literature (reminiscent of studying anatomy), and the fact that the MGH surgical house staff weren't very good listeners when it was my turn to tell a story. Come to think of it, the trouble I had locating our dog's appendix in third-year surgery may also have undermined my confidence early in the game.

It was during my fourth-year medicine rotation at Boston City Hospital that I actually felt myself becoming a physician. On other rotations I

had been quite content with the role of student, but on the Fourth Medical Service, merely by being thorough, I detected an early cervical carcinoma in a woman who had been admitted for another reason. I assisted in diagnosing tuberculosis in two or three patients by checking the chest X ray and doing an acid-fast stain to see the TB organism. There seemed to be action enough, and a combination of thoroughness and caution could make up for a lack of brilliance. About this time I discovered that discussants of the weekly clinical pathological conferences published in *The New England Journal* had been given the cases weeks before, and that their discussions were something other than spontaneous responses to a case recited by the house officer. I chided myself for being naive, but was enormously reassured.

I enjoyed the camaraderie as well as the calories of the midnight supper at BCH and felt like a seasoned veteran after having served one month in June—compared to the scared new interns starting in July. That summer I learned about the University of Utah from one of its graduates, Bob Stewart, a gifted young physician near the end of his internship. I believe the term "role model" applies. I put Utah on my list, but, being a Bostonian, had no idea where it was on the map.

That year the hospitals of the University of Utah drafted seven members of the HMS Class of 1960. Noreen Koller commented as she handed me my envelope, "You're going to get in

a lot of skiing," without mentioning the name of the hospital. I didn't know what she was talking about. It was news to me that there were any mountains in Utah, let alone the best skiing in America only 45 minutes from downtown Salt Lake!

Our class has lived through interesting, exciting, and tragic times. In the fall of our freshman year, the Suez crisis erupted and the Anglo-French-Israeli military action against Nasser's government kept some of us glued to our radios. Castro's revolution overthrew the Batista government while we were in the third year; many of us went to hear him speak when he came to a rally near Harvard Stadium that summer. The following year Jack Kennedy was nominated for president. I happened to be in the audience in the Mormon Tabernacle when Kennedy chose to discuss what was then described as *The Catholic Issue*. He got a frosty reception from the Mormon Elders sitting on the dais; he was from the wrong party, the wrong part of the country, and the wrong religion. Nevertheless, he gave a wonderful speech, and was well received by the packed house. It was an exciting time.

East-West relations began to sour, and there was a military buildup. The doctors' draft in the spring of '62 netted a few of our class, and forced others into the protective custody of the National Institutes of Health and the U.S. Public Health Service. The draft may have been responsible for the high percentage of our class going into academic medicine!

During the political turmoil of the next few years, I and most of my classmates were hard at work finishing our training and launching our careers. I was in my first year of a nephrology fellowship at Tufts New England Medical Center when John Kennedy was killed. In 1965, I moved to Pittsburgh, where the confluence of the Monongahela and the Allegheny form the Ohio River. (The Muddy River, by the way, runs through the Fens about half a mile from HMS.) I joined the faculty at Pitt Medical School and the medical staff of Montefiore Hospital, and married Elizabeth that summer. In the last five years of the '60s, my personal joy at being newly married and having a son and newborn daughter contrasted with the deepening Vietnam tragedy, the Martin Luther King and Robert Kennedy assassinations, and the chaos

in our national life.

Pittsburgh was one of the cities in which martial law was declared during the riots following the King assassination in 1968. The troops were bivouacked in Pitt Stadium, a few hundred feet from Montefiore Hospital. I went in to the hospital every day, and even managed to get my weekend tennis game in, although the courts were almost deserted because of the acrid smell of smoke and the disturbing noise of Army and police helicopters flying overhead.

I had great empathy for the victims of the tragedies of American life, but no great courage—no taste to put more than my vote and some of my money on the line. I did belong and contribute to civil rights organizations, but mainly I went to work every day, tried to contribute to the teaching program of my hospital and the medical school, and to be a good husband and father. My son Kenneth, in an essay published last year in his high school literary magazine, wrote: "I remember watching the CBS evening news with my father when I was very young. The death count each day was around 23... I'd think to myself, that wasn't too many... for a war." Those numbers seem more weighty now to an 18-year-old and his parents.

As I reflect on my life and the events of the last quarter century, I count myself among the most fortunate of individuals. I have been privileged to pursue a career with remarkable freedom. I value the friendships made here at HMS, and regret the difficulty in keeping them current. I'm saddened, with the rest of you, by the loss of classmates and some close friends, but rejoice that so many have maintained their health. I am grateful to at least six Harvard-affiliated teaching hospitals and a score of faculty physicians for the expert and humane care provided to my parents and me since my birth at the Boston Lying In a little over 51 years ago.

Though I am anxious about the future, I'm also optimistic, and frequently make resolutions to keep me looking to the future. My current resolution is to start preparing my 50th Reunion talk *before* May 25, 2010. I hope to see you all there. □

David Segel '60 is associate professor at University of Pittsburgh School of Medicine, and associate head of the Renal Unit and director of ambulatory care at Montefiore Hospital.

How in the World Did I Get Here?

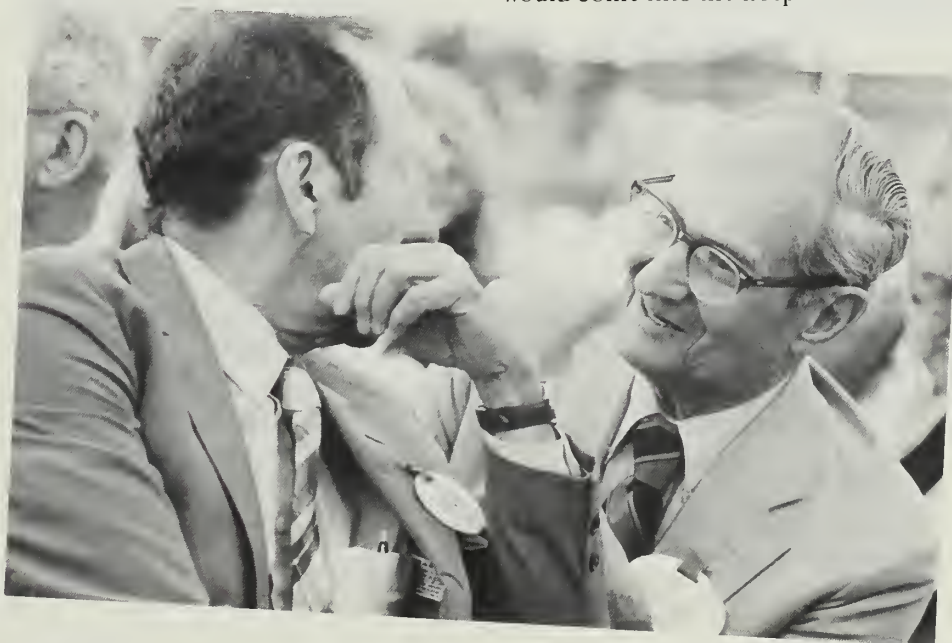
by Walden B. Whitehill

WHEN I GRADUATED FROM Harvard Medical School 30 years ago, I had a pretty good idea of where in the world I was and where I intended to go. I was going to get an internship and residency and go into small-town private practice someplace in the West or Midwest. Well, the internship and residency went pretty well according to plan. Then there was a two-year interlude in the Navy, which I wasn't counting on, but which was still pretty good. I came to understand a little about military life—and that understanding has helped me in these days when the military occupies such a major part of our attention and our pocketbook. But after my stint in the Navy, my life began to deviate from my plan.

I found myself five years after graduation being a missionary in Hong Kong treating Chinese patients. Some of you who knew me in my more reckless days here as a student may find that hard to understand or believe. I practiced in Hong Kong for



15 years, and my practice was entirely in Chinese. I taught students and student nurses in Chinese and eventually came to be able to correct their papers written in Chinese. I found myself treating leprosy, cholera, filariasis, typhoid, snake bites (mostly bamboo and cobra), and surviving typhoons when electricity would go out for a couple of days, and when all the women in labor would come into the hospital because



of the depression. I had to dig out old parasitology and tropical medicine books that I'd had here at HMS and start re-learning. Grateful patients would arrive at my door presenting live chickens, on occasions live snakes in burlap bags. One man particularly enjoyed cooking up dog-meat stew, and not only presented it but sat down with us to eat it, so we had no escape.

The conditions of my practice at that time were quite good. The physical setup was rustic. The symptomatic medications we used sounded like they came out of the old English apothecary—things like Linctus Gee, mixture carminative, turpentine cough mixture—but the basis of our practice was solid and we tried to practice medicine of the highest quality we knew.

In the first years I spent much of my time treating tuberculosis, a subject that had not attracted me in any way during my medical student years. But, determined to do a good job, I came to know it. I eventually found that we were not only practicing good care for tuberculosis, but actually spearheading some of the investigational programs with the British Medical Research Council, some of which have led to our present-day program of multi-drug therapy, short-course therapy, and so forth. I was able to help introduce some modern respira-

tory equipment into our hospital program.

I also learned that the British use of umbrellas in the tropics has a second valuable aspect. When you're making an emergency call in a Chinese village at night, you can make it all the way to the house without dog bites by putting up the umbrella and fending off the animals.

Our living conditions in Hong Kong were pleasant, even romantic at times, but with some distractions. You probably are all aware of the water shortages that have plagued Hong Kong for quite a few years. We often would come to a point of absolutely no water and would have to carry it by bucket. For 13 months water flowed through the public pipes only four hours every four days. We were on malarial suppressants for the first few years, until malaria was eradicated in Hong Kong. Both my children developed childhood tuberculosis but came through all right. We discovered snakes in our yard frequently, and one time a coral snake in the living room. Our home also was disturbed by typhoons, in one of which we lost about three-fourths of our roof. And as I walked past open sewers where night soil was being tipped out of wooden buckets, I wished I had made it to more of those

preventive health lectures at HMS instead of slipping across the street for a beer. So many times during those 15 years in Hong Kong I asked myself: How in the world did I get here?

In 1975 we returned to the United States, a radical change. The next thing I knew, I was working in a maximum security prison as a medical officer with the Public Health Service. I spent the next eight years in prison health work, first at Leavenworth, Kansas, and then in Atlanta, Georgia. The contrast between missionary life in Hong Kong and a maximum security penitentiary is as great as any I could imagine. The language alone was a complete revelation, the types of medical problems were quite different, and I had to relearn some lessons, from my days at the Cook County Hospital emergency room, to distinguish between "stobbins" and "sloshins." And whereas in Hong Kong patients frequently expressed their gratitude, prison patients are often hostile. Working in prison turned out to be a real challenge—probably the most difficult job I've ever done. Again the thought came to me frequently: How in the world did I get here?

The first priority in a prison is keeping the prisoners inside the walls, which sometimes makes practicing medicine difficult. I also had to learn the basics of surviving and keeping myself safe. But the medical practice was much as I had known it. We had to take care of a lot of acute trauma and delayed events in the life of violence many of our prisoners had experienced. There was a large degree of psychiatric illness; I had to fall back on my days at Boston Psychiatric Hospital to refresh some of those definitions of psychiatric illnesses I had learned.

When the Cubans were detained at the Atlanta Penitentiary starting in 1980, they brought new problems. A more neglected population I had never dealt with: simple hygiene practices were not known to many of them, and they were much more sexually active and promiscuous even than the American prison population. Within a few months we were facing a major syphilis epidemic and many related problems, such as hepatitis, in the Atlanta Penitentiary. I had to relearn parasitology, as they brought a good deal of intestinal parasite infestation from Cuba. We found almost everything—except, for my classmate Kenny Warren's sake, we



didn't make a single diagnosis of schistosomiasis.

The two principles that guided me in my prison work were respect for each individual I treated, no matter what kind of mistakes he might have made in life, and demand for quality of care even under prison conditions. There were constant challenges; two that stand out were the difficulty in improving attitudes of prison hospital staff to a standard of professionalism, and attracting and retaining good-quality medical staff. As you can imagine, practicing in prisons is not the most popular medical pursuit.

One special event was finding marijuana growing in a window box in our ICU at Leavenworth. Another was discovering home brew perking away in the isolation ward in the same penitentiary. I also recall many brutal assaults by prisoners on one another; and the use of the hospital bathtub for baptisms, that being the only bathtub in the institution (showers being used for general cleanliness). I remember too the time I spent in court learning to be a good witness, reflecting back on the one lecture we had on forensic medicine here at HMS.

The high points in my time working in prison health were representing the Prison Health Service as I audited health facilities in correctional institutions around the country; sitting on examination boards for paramedical qualifications of personnel around the country; and being asked by the Justice Department to do an evaluation of the health-care facilities of one of the state correctional institutions. All these tasks gave me an opportunity to influence the course of events and improve standards of health care in U.S. prisons.

The most recent chapter of my life has taken place at the Indian Health Service in Santa Fe, New Mexico, to which I was transferred two years ago. As if I were not far enough astray from my original plan, I found myself in yet another culture and geographic area with which I was unfamiliar.

I think the cultural and economic aspects of the environment affect the Indian people's health care more than that of any other culture I've known. The frustrations many Indian people experience in wanting to hold on to their cultural past and customs, and at the same time trying to compete economically with a modern U.S. so-

ciety, has had its toll. Alcoholism—and all the trauma and motor vehicle accidents that stem from it—is still the great problem it has been in recent times. Some of the other problems include lack of accessibility and transport for the widely disbursed rural Indians, the prevalence of Type II diabetes, and delayed treatment. In no area is preventive medicine more needed—and less funded—than it is today in Indian health care.

Senator Bingaman has introduced a bill in Congress to mandate the use of preventive medicine in IHS, but with no additional funding. Insufficient funds have played a major part in limiting the ability of IHS to serve Indian people. I have experienced shortages before, but it seems to be having a more profound effect at IHS than at any of the other programs. The time is ripe for the Indian people to express self-determination, and it's exciting to be around to help guide that effort.

It's been a long and interesting road, one that has brought many unexpected medical experiences, many of which found me unprepared—but it has never been dull, never without challenges, and seldom unrewarding. My HMS education prepared me well for the unexpected. The often-touted claim that a Harvard medical education is unique in giving the broad basic foundations in

medical knowledge has seldom been tested so much as it has by me—and found to be true.

How in the world did I get here? I have asked many times, and seldom found a good answer. I see some common threads as I look back, however. Although the works with which I was involved were poor in terms of dollars, they made more than a small contribution. In any setting, patients—be they Chinese refugees in Hong Kong, prisoners in the Atlanta Penitentiary, or Indians in New Mexico—quickly come to know when their physician cares and does his utmost to bring them quality care.

Others of you may also have taken the less traveled path in your medical careers, and may share my feelings that the road we travel isn't as important as the way we travel it. The principles we maintain in bringing high quality of care, accepting challenges, growing constantly in our abilities, and looking at the needs of others are lessons we all have learned. I find truth in this statement by John Stuart Mills: "Those only are happy who have their minds fixed on some object other than their own happiness." Thanks for listening to a personal tale of an adventurer in the grass roots of health care in several different cultures. □

Walden B. Whitehill '55 practices primary care medicine in the Indian Health Service in Santa Fe, New Mexico.



Don Bowen: Bridging the Gap Between Two Nations

by William Fletcher

A note from Will Cochran '52, director of alumni relations:

There is a segment of Harvard Medical School alumni in which I am particularly interested and almost fiercely proud: those who devote their considerable energies working in the impoverished vineyards of clinical medicine. They have generally not gone to Central America, Ethiopia, or Vietnam refugee camps, but have shown an equally burning interest in improving the health of their impoverished neighbor. Unfortunately, generally until they retire or die, they are our "unsung heroes." They might even feel HMS is not really proud of them.

I know I don't speak only for myself when I say we HMS alumni are interested in and proud of not only our illustrious, nationally or even internationally renowned graduates, but also our lesser-known heroes. I hope that in time we may be able to recognize such exemplary people before they die. Perhaps we can create an annual award. Here's a report on one who would have been a contender.

Adoniram Van Bowen, a Creek Indian from rural Oklahoma, was one of the first Native Americans to graduate from Harvard Medical School. On December 27, 1984, he died from a ruptured cerebral aneurysm at the age of 40. Although Don Bowen may not have been the most honored of Harvard's illustrious alumni, he was one of its most distinctive.

Being a Creek Indian myself, and

an HMS student at the time, I was asked last winter to write this short biography of Don Bowen. Although I had met him briefly at an annual conference of the Association of American Indian Physicians, I had not known him well. I traveled to Oklahoma this spring to visit his widow and co-workers; as the details of his life unfolded, my fascination and admiration for this man grew.

Bowen was a citizen of the Creek Nation, a tribe of American Indians located in central eastern Oklahoma. The tribe was forcibly removed from Georgia and Alabama following the Indian Removal Act of 1830, and brought to Indian Territory along the "Trail of Tears." The Creeks became known as one of the Five Civilized Tribes—along with the Cherokee, Chickasaw, Choctaw, and Seminoles—as they quickly established independent legislative, judicial, and educational systems. The Dawes Severalty Act in 1887 was the first step in forcing the tribes to divide their communal property into individual holdings and release the remainder for non-Indian settlers. Within a few decades, the Five Civilized Tribes had again lost most of their property and power.

Although most Creek Indians live in a few adjoining Oklahoma counties, the tribe has never had reservation property. Only recently has the Creek Nation established a new tribal government complex, subsidized housing for the elderly, a tobacco and smoke shop, a bingo parlor, and a tribally owned health-care delivery system.

Born on July 1, 1944, in Henryetta, Oklahoma, Bowen attended grade school in Dustin and graduated from high school in Seminole—three of the numerous small towns that punctuate the rolling farmland of central



Oklahoma. Many of the villages in this region consist of little more than a gas station, grocery store, and church. The sweltering summers with oppressively high humidity drive many local residents to Lake Eufaula, a large man-made body of water a few miles to the east, to seek relief through swimming, fishing, and boating. Nonetheless, insects and reptiles thrive in the heat far better than humans.

When reminiscing about his childhood, Bowen often referred to the poverty of rural Oklahoma. It is still common to see ramshackle houses surrounded by rusty automotive wrecks amid unmowed grass. Bowen—an only child raised by his mother—did not live in a house with running water until he was 13 years old. “I remember going to the welfare office to borrow five dollars for food,” he recalled in the *Association of American Indian Physicians Newsletter*. His mother once suggested that he drop out of high school to earn money, but he persisted with his education.

Following high school, Bowen worked full-time to save money before enrolling at the University of Oklahoma. He received a bachelor's degree in pharmacology in 1970, then made a last-minute decision to apply to medical school. He had considered pursuing a career in either law or medicine, as he felt members of these two professions were most needed within the Creek communities. After hearing that HMS was recruiting Indians for a new minority program, he applied only there.

David Potter, then professor of neurobiology (now also head of the Department of Neurobiology) conducted Bowen's faculty interview. “From first acquaintance Don Bowen seemed a completely trustworthy person,” Potter recalls, “unshakably committed to improvement of Indian health care, and determined to obtain the best possible education for this purpose.” Bowen stayed in touch with Potter during his years at HMS. “His attitude was to learn as much as possible for the sake of his goal,” Potter says, “even when the faculty's purposes were not the same as his.”

Bowen was one of five minority students in a special program that included one year at Harvard College to fulfill premed requirements prior to matriculation. He was the only one of the group to graduate from HMS in 1976. “Don literally battled his way through medical school,” his mother remembers. “His premedical education had been a very inade-

quate preparation for the rigors of Harvard, and at times he had to struggle.”

Bowen not only had to contend with the demands of medical school, but find time for his new family as well. While studying at Harvard College, he met and married Michal Ann Horowitz, a student at Wellesley. Their oldest daughter, Anna, was born while Bowen was still a medical

Many villages in rural Oklahoma consist of a gas station, grocery store, and church. It is still common to see ramshackle houses surrounded by rusty automotive wrecks amid unmowed grass.

student. According to one of his friends, Michal's emotional support was crucial to Don's success both during and after medical school.

“Don's greatest obstacle at Harvard was knowing that some people wanted him to fail,” Michal Bowen says. “He realized that a few of the professors and students felt Harvard had lowered its standards to let minority students in, and he felt pressured to prove himself.”

Michal Bowen recently wrote Daniel Federman '53, dean for students and alumni:

I know Don was very proud of his association with Harvard Medical School. Successfully completing the requirements at HMS was one of the hardest challenges he ever faced in his life.

Many times he knew he could accomplish whatever task was before him because of what HMS had taught him. I think HMS teaches all its students a great deal. For someone like Don, who grew up in an environment that did not encourage his potential, HMS gave him the self-esteem and self-confidence to accomplish a great deal in a few short years.

After finishing a family practice residency in Glen Cove, New York, Bowen returned to Oklahoma in 1979. By then his family had been enlarged by the birth of twins, Emily and Jenny. Don worked as a staff physician at the newly opened Creek Nation Community Hospital in Okemah.

Originally this 39-bed facility had been owned by the predominantly non-Indian community of Okemah (population 3,381). Local Creek Indians claimed they had been denied medical treatment there in the past, and that they had been forced to drive up to 100 miles to the nearest Indian Health Service hospital. For various economic and political reasons, the Okemah Hospital was closed; it was subsequently purchased by the Creek Nation. Creek citizens now come from around the area for free health care at the renamed Creek Nation Community Hospital (CNCH). The local non-Indian population continues to receive medical treatment on a fee-for-service basis.

Bowen began to practice medicine within this somewhat antagonis-



tie setting. He used his astute political skills to foster reconciliation of the community's various factions. He also joined the Kiwanis Club and served as member and eventually president of both the Okfuskee County Board of Health and the Okfuskee County Medical Association.

During the five years he served at CNCH, Bowen won the respect and admiration of his co-workers and patients. A quiet, modest man easily roused to laughter, he was honored by the trust of the traditional full-blooded Creeks. Sioux Pepper, head nurse, praised Bowen's "excellent bedside manner, the best I've seen." Bowen's genuine concern was evident in his unsolicited phone calls to follow up on isolated patients, and in his ability to remember individuals and their life situations years after meeting them. Gene Clover, a hospital maintenance man, reflected the feelings of all Bowen's co-workers when he said: "We lost not only a fine physician, but a good friend as well."

Named chief of staff at CNCH and medical director of the Creek Nation in 1981, Bowen envisioned a comprehensive health-care delivery system for all Creek people. He was a strong supporter and promoter of the satellite outpatient clinics in Okemah, Sapulpa, and Eufaula. He played a central role in the tribe's implementation of the Indian Self-Determination Act to provide medical services on contract to the Indian Health Service (IHS). CNCH remains the first and only hospital owned and operated by an individual tribe.

When he was a first-year medical student, Bowen told the *Bulletin*, "It is the business of the Indian to rebuild the identity that the larger society has attempted to destroy." He emphasized the need for more Indian physicians, saying that Indian students must be made aware that medical school is accessible to them.

"Don Bowen was one of the tribe's most highly visible role models, and he raised the aspiration and self-esteem of the kids," attests Mark Downing, human development director of the Creek Nation. "He inspired everyone he met through encouragement and through example."

A local vocational school made Bowen the subject of an educational videotape shown to area high school students. In the tape, Bowen recalls that when he was a child it was un-

heard of for Indians to become professionals, and he encourages people of all ages to pursue their dreams. He endorses the maxims that through hard work anything is possible, and that individuals can improve the quality of life for all.

One of Bowen's special interests was the Association of American Indian Physicians, a 13-year-old, 76-member national organization dedi-

Don Bowen had considered law and medicine, the two professions he felt were most needed in the Creek community. After hearing that HMS was recruiting Indians, he applied only there.

cated to improving the quality of Indian health care and increasing the number of Native American physicians. Bowen began attending AAIP's summer conventions as a medical student to renew his commitment to Indian health-care issues. He was later instrumental in organizing the 1982 conference held in Okmulgee, Oklahoma, sponsored by the Creek Nation. During his term as AAIP president from 1983 to 1984, Bowen helped initiate the organization's search for new revenue sources to offset the dwindling financial support of the Federal Health Resource and Services Administration. He and other Creek Nation officials made several trips to Washington, D.C., on behalf of AAIP to testify before congressional committees and to lobby for continued support of Indian health care.

The multiplicity of Bowen's interests and talents led Charles Crowell, a physician at CNCH, to describe him as a "broad-spectrum physician." Bowen was equally at home talking with a congressman or explaining medication schedules to elderly Creeks. He was associate professor at University of Oklahoma Medical School; he particularly enjoyed clinical instruction. He also appeared on "NOVA," a public television program.

Don Bowen was a dedicated family man. His wife described his relationship with his daughters in a memorial letter to the *AAIP Newsletter*:

"He could open up, relax and laugh, watch cartoons, play with toys, hide in the closet and jump out and say 'boo!'. . . . He wanted them to be proud he was their daddy." Bowen jealously guarded his time with his family, and frequently left Okemah on weekends to escape from the telephone.

In the fall of 1984, Bowen resigned his position at CNCH, transferring to the Creek Nation Clinic at Sapulpa. He felt he had accomplished all he could at the hospital, and had begun to formulate plans for his next goal. "I'm a builder, not a manager," he often said.

Shortly before his death, Bowen discussed with IHS director Everett Rhoades the possibility of attaining a master's degree in public health and joining IHS. Rhoades recalls, "I was very excited about the idea of Don working for IHS. He clearly had the potential to be a leader in Indian health care in the country. His untimely death was a great loss not only to his family and the Creek tribe, but to all Indians."

Considering Don Bowen's many accomplishments during the six years between his residency training and death, it is difficult to imagine what he might have achieved had he lived longer. Michal Bowen describes her husband as "someone who always dreamed big. He always shot for the moon, but more often than not he made it." His life story is a classic American tale of upward mobility in the context of uncommon altruism.

Bowen brought to life the dreams of two nations. He was an inspiration to the Creek people, living proof that it is possible to bridge the cultural gap so as to improve the quality of tribal life and still retain what is inherently Creek. He was the right man at the right time to fulfill a great need. In the words of David Potter, "He was a leader of a particularly non-redundant kind."

My Creek grandfather used to remind his children that their every action was a reflection not only upon themselves, but upon their family, clan, and tribe. By being true to himself, Don Bowen brought joy and pride to his family and fellow Creeks. □

William Fletcher '85 is now a first-year resident in medicine at Mayo Graduate School of Medicine in Rochester, Minnesota.

Where's Charlie?

by J. Gordon Scannell



Nature, says the second law of thermodynamics, never gives you anything for nothing. Now some engineers in Boston have come close to defying that unbreakable rule. They have produced a building that heats itself without a furnace or conventional fuel and remains warm even during such blustery periods as the recent cold spell, when Boston temperatures plunged to 0 degrees F. The building performs this scientific magic by a cunning engineering stratagem: it recaptures the waste heat of its own machinery, everything from computers to coffeemakers, as well as of the 2,000 people who will eventually work inside it. (From Time.)

Legendary heroes are hard to pin down; facts fade in and out as if being focused on a pathology slide. I learned this a year ago when I tried to find out about Charlie.

Alumni are said to have fond memories of the M.T.A., now called the "T." If they are of the right vintage, they remember Charlie. If they have reached that senior citizen status which allows them to ride the M.T.A. for a dime, they may forget briefly "the lean and slippered pantaloons" and remember Charlie's fate.

Who was this Charlie of legend? What, for heaven's sake, does the spectacular new Transportation Building in Boston have to do with him? Here's what that old friend, the *Boston Globe*, let me say last year:

The new Transportation Building is a world of wonders. You stand in its lofty atrium, warmed by the body heat of thousands. You gaze upward, you look around, you think, "something's missing." You wonder about all the people around you who commute to work, and you think about the most hapless commuter of all—the legendary "Charlie."

Charlie was everyman's Flying Dutchman, doomed to ride forever 'neath the streets of Boston. Thirty-five years ago, his fate stimulated one of the great campaign songs of all time, a call to action second only to the Marseillaise. The citizens of Boston were exhorted to "fight the fare increase, vote for George O'Brien, and get Charlie off the M.T.A."

The fare increase was a complex matter that involved payment of an extra nickel to get off a streetcar. The regulation was in effect only a short time, but, according to George Sanborn, librarian for the M.B.T.A., it gave rise to great merriment among public transport managers outside Boston.

The slogan is genuine. The song is witness to the fertile imagination of the Kingston Trio. If we must be truthful about it, it was not used as a campaign song.

George O'Brien's real name was Walter Bryan. His campaign for City Council foundered. Alas, he is no longer with us. But Charlie is just as real as if he had once been.

Poor Charlie had only one dime when he took the Red Line from Kendall Square Station and changed for Jamaica Plain at Park Street. Lacking the extra nickel, he faced a tragic dilemma. He could never get off that train. The human tragedy is vividly illustrated in one verse of the ballad:

*Charlie's wife goes down to the Scollay Square Station
Every day at quarter past two,
And through the open window she hands
Charlie a sandwich
As the train comes rumbling through!*

Whatever happened to Charlie? He should by now have reached senior citizen status, and a dime once again is all he needs to ride the M.B.T.A.

We don't know what happened to Charlie, but we can put together a hopeful scenario built upon the assumption—and there is no evidence to the contrary—that he was at least 30 years old on that fateful day in 1949 when he entered the Kendall Square Station just prior to the fare increase.

Eighty-four minus 49 equals 35; 35 plus 30 equals 65. Sixty-five is a number that looms large for many of us. As a senior citizen, I'll bet Charlie finally got off the M.T.A!

Contrariwise, George O'Brien did not get on the City Council, though his sense of humor would have made him a useful member. True, he did receive many gifts of food and money and discarded clothing for Charlie—but, sadly, not enough votes for George. The rumor is false that he had a brilliant career as a streetcar operator for the M.T.A. His political career foundered and he exists only as a pseudonym.

Surely, in the new Transportation Building there is room for a chapel or meditation room or, at the very least, a Strap-Hanger Lounge dedicated to Charlie. This would be a place of light after a dark journey, a final vote of confidence in George O'Brien.

Now for some facts. In the original draft the idea that the Transportation Building is a festival of pheromones succumbed to the editorial blue pencil, not, I suspect, because it might offend the reader's sensibilities, but rather it might call to mind his or her ignorance. The building is such an unusual and instructive phenomenon, a short description and picture are reprinted with permission from *Time*, January 9, 1984.

The slogan is genuine. "Fight the fare increase, vote for George O'Brien, and get Charlie off the M.T.A." The tune is taken from "The Wreck of the Old 97"; the words are by Jacqueline Steiner and Bess Hawes, campaign workers for "George O'Brien." I am happy to say that "George" has not passed over, but lives happily with his wife on the coast of Maine. He is not anxious for any more public notice, thank you very much, and we will not identify him further. The Charlie piece in the *Globe* no sooner appeared than a series of telephone calls from "George's" friends let me know I was wide of the mark. So, in truth, were his friends, who had him

living in the wrong town, but some intensive detective work, real F.B.I. stuff, put me in touch with our hero's cheery voice.

In truth he was an unsuccessful candidate for mayor. His campaign song did not go out over the radio, but was broadcast by truck. The song was quite a favorite of the patrolman at the corner of Summer and Washington streets, and he allowed the sound truck to tarry there beyond its allotted time each day while workers circulated petitions to stop the fare increase. *Folk Song Magazine* in 1960 noted that publishing the "Charlie" song produced a deluge of protests from Boston because the song made a hero out of a local "radical." The real hero lives on behind the camouflage of "George O'Brien."

As for Charlie, I must report that there has been no Second Coming. Even more distressing, no sign of a Strap-Hanger's Lounge; no word from the Kingston Trio. But graduates of Harvard Medical School, hear me out! Write your congressman; all is not lost! Take up the call: "Stop the 'T' for Charlie!" □

Charlie's wife with sandwich



ILLUSTRATION BY ERNEST CRAIG

REUNION REPORTS

55th Reunion

At our 55th reunion dinner on June 6 in the Aesculapian Room at the Old Harvard Club, our well-known and popular professorial classmate Arthur Hertig spoke to us with his usual humor and understanding. "We are a unique class," he said, "'unique' coming from Latin, meaning 'one' and 'unequalled.' All we have in common are an M.D. degree and our Class of 1930. It will be clear as the evening goes on just how unique we are, since later I intend to ask each of you how you happened to go into medicine

and to come to Harvard Medical School, and what you have been doing since."

Hertig's prophecy was well borne out by the end of the evening, after his classmates had had their say and he had recited his own ventures in entering and achieving the heights of his distinguished OB-GYN pathology career, starting by working with Dr. Wolbach and culminating with being inducted as a fellow *ad eundem* into the Royal College of Obstetricians and Gynecologists, and receiving the American Association of Pathologists Gold-Headed Cane Award.

Hertig concluded his remarks with Shakespeare's familiar line: "There's

a divinity that shapes our ends/Rough hew them how we will." But he promptly qualified this sentiment by quoting Pasteur: "In the fields of observation, chance favors only the prepared mind"—implying that whatever success we may have had in our medical careers should be credited to our great educational heritage from HMS, not to divinity or chance!

The Reunion Committee, through its ghostwriter, "Mr. Mouse" (a mythical story-telling character dreamed up 50 years ago by a certain mouse-loving member of our class), added a light-hearted spark to the evening by passing out a printed skit entitled: "Who Were We? An ABC of Edsall's



Merry Medical Mice of 19 and 30." A condensed excerpt, using only the names of those attending the dinner, is attached hereto for the information of those who have time for such frivolity.

A is for Maurice Abrams and Robert Aird, Boston internist and U. of Cal's internationally renowned neurologist, respectively. B is for William Babson, our AWOL salmon-fishing surgeon from Annisquam; for irrepressibly eloquent Benny Banks of Beth Israel gastroenterology; and for Leo Blacklow, our still-practicing demon dermatologist from Belmont. C is for Jack Caughey, emeritus dean of Western Reserve (who was once caught climbing the lamppost outside Vanderbilt Hall one spring night in 1930); for Dick Collins, our Distinguished Service Army major general (of the Artillery Corps, no less), who practiced surgery skillfully in Waltham for several years before joining the Army; for Ed Cole, clinical and research neuro-psychiatrist at MGH; and for G.P. Henry Clarke, better known as the "farmer and forester" of Ashfield, Massachusetts. D is for that genial and always considerate MGH staff internist, Bry Decker.

F is for Jack Frazee, popular otolaryngologist, now residing on Cape Cod; and for Hal Freeman, the quiet but effective example of the vanishing family doctor, who is still continually involved in community and medical society activities in Somerville. G is for peripatetic Ralph Gause, clinical professor of OB-GYN in Vermont in the summer and Board of Health consultant in Mississippi in the winter. H is, of course, for Harvard, but also for many of the most stalwart members of our class, including two top-notch pathologists, Art Hertig and his midwestern counterpart, Beach Hazard of Western Reserve; Ned Holmes, chief of ENT at Newton and plastic surgery chief at Massachusetts Eye and Ear Infirmary; and, by all means, the Hugenbergers: Paul, orthopedic consultant in Boston and the North Shore, and Frank, OB-GYN professor at Ohio State.

I is for In Memoriam for 66 members of our class, and for In Absentia for 29 classmates who could not attend the reunion. We miss you "IA's," and hope to see or hear from you in the near future. K must be for Lee Kendall, the ever cheerful, hard-working Framingham surgeon who was such a great chairman for our 50th reunion but was AWOL this year

because of recent surgery. Everyone knows and admires Lee! K is also for historically-minded A.G. King, "something-or-other emeritus" OB-GYN surgery in Cincinnati. L is for "Dutch" Ludwig, our psychoanalytic class president; and for Bren Leahey. N is for Bill Nevius and Paul Norton. Bill retired from his busy pediatric practice in East Orange, New Jersey, in 1975. Paul capped his distinguished orthopedic career by dedicating the Paul L. Norton Medical Library at Massachusetts Hospital School in 1984.

P is for Pilcher, retired surgeon ("Mr. Mouse"). R is for psychiatrist Josh Reynolds, who presented us with his well thought-out "personal panoramic purview" of life and urged us to "Grow old along with me/The best

is yet to be!" W is for three rugged workaholics: Dave Wallwork, North Andover surgeon and very successful class agent; Ed Wayburn, internist and mountain climber from California; and Martin Woodall, still practicing psychiatry in Jamaica Plain. Z is for Norbert Zielinski, Newport, Rhode Island, surgeon, who once lived up to reunion editor "Hammy" Hamilton's 1970 comment: "No message from the Silent Pole. As far as we know, he's heading for Mars." But lo and behold, Norbert appeared at our 55th in person, under full sail, and was welcomed back from Mars with open arms.

—Lewis Pilcher



50th Reunion

On June 6, 7, and 8, the Class of 1935 celebrated its 50th reunion. All but a few of the 86 members of the class responded.

On Thursday there were interesting scientific sessions to attend. In the evening Dale Friend arranged a cocktail party followed by an excellent catered dinner at Countway Library. Mark Altschule '32 gave an amusing talk after dinner.

On Friday Alumni Day was celebrated. There were speeches, class photographs, and a luncheon on the

Quadrangle. In the evening we enjoyed a good dinner at the Union Club with a pleasant talk by our president, Phil Partington.

Saturday was "marine day." A large group of us embarked on the motor vessel *Freedom* for a trip around Boston Harbor. The captain was female and an expert at navigation. In addition to running the boat she gave commentary on the sights of the harbor. We had a lunch of chowder, steamed clams, boiled lobster, vegetables, and watermelon. All in all, an enjoyable trip and a fitting end to a very good reunion.

—Lamar Soutter

45th Reunion

This was the greatest, friendliest reunion of the Class of 1940. We learned on Thursday, listened on Friday, then socialized and played on Saturday and Sunday.

Seventy-one gathered at the Tavern Club on Thursday evening. It was a pleasure to see so many classmates and their wives. After a tasty meal the time was filled by raconteurs par excellence—much fun. After Alumni Day on Friday, 44 gathered at Chatham Bars Inn to savor its attractive facilities and sumptuous meals. From there some went whale watching (a great show: 40 whales), while the remainder played golf or tennis or visited the lovely town of Chatham.

Saturday evening Bob Arnot, Sam Potsabay, and Tom Paull showed slides of their trips. Ed Grafton told of his visit to Russia with fellow ophthalmologists. We had a repeat of the famous "Chewing Gum" song by Wister Meigs. We even celebrated two wedding anniversaries with a champagne toast. It was a most enjoyable



time—although Arch Deming could not attend because of a hand injury requiring immediate surgery.

Sunday we said farewells, vowing to gather again at our 50th.

Much credit and thanks go to Tom Paull for his work as editor, Dorothy

Paull for contacting class widows, and Bill Hickey for his continuing help as class treasurer.

We all say, "Plan to come to the 'big five-0!'"

—Rodney C. Larcom Jr.

40th Reunion

The reunion dinner at the Country Club on Thursday night brought out a larger crowd than was expected. It was great remembering familiar faces that we hadn't seen in so many years.

How quickly the warmth and comfort of old friendships is renewed.

Friday we got together for lunch on the Quadrangle and a class picture. Then it was off to the Wequasset Inn in Chatham, where we were wine and dined royally. Saturday was on the cloudy side but not enough to keep us away from the courts, the

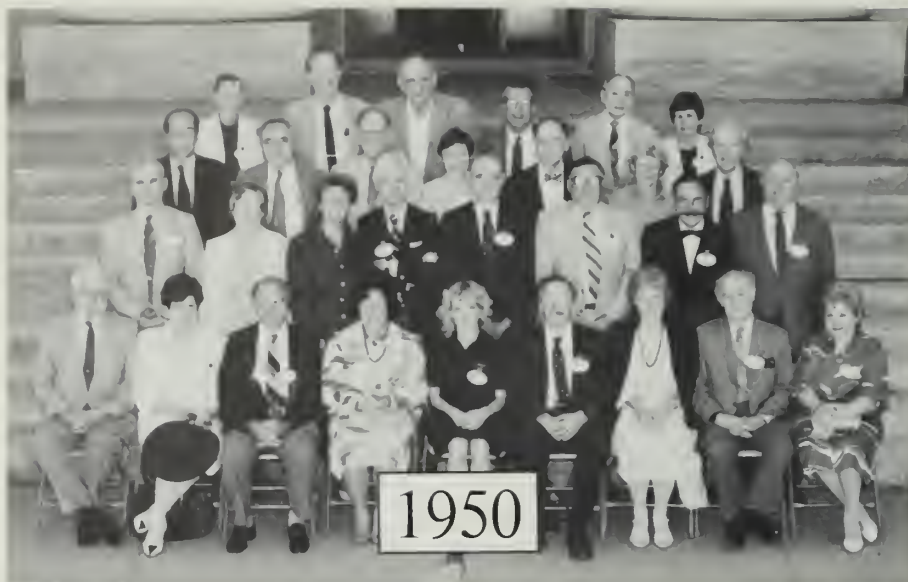
course, and seeing the sights. A beautiful clambake was served at supper. We departed Sunday with promises of keeping in touch.

—Edward W. Friedman



35th Reunion

Our 35th reunion provided a satisfying opportunity to touch base with one another again. The setting of our first gathering of 58 classmates and significant others on Thursday was the Union Club—a nostalgic bit of old Boston—for cocktails and dinner. The conviviality was followed by spontaneous after-dinner remarks by many, tactfully monitored by Frank Williams. The major tenor was serious concern at the changes from the medical world we entered to the present shift of power and control of delivery—and threat to the quality—of care. On Friday, Don Gair's Alumni



Day talk, "The Metamorphosis of 'Patient' into 'Client,'" touched on an aspect of these concerns.

When 32 of us took off for the weekend at the Wequasset Inn on Cape Cod, the mood lifted steadily, escalating to wit and hilarity at the

Saturday evening clambake and dance. By brunch on Sunday we were loath to part, and wishing more of you were there. Perhaps you will be next time.

—Evelyn Davis Waitzkin

30th Reunion

Encouraged by a splendid 30th Reunion Report edited by Eleanor Gossard Shore and William J. Adelson, the Class of '55 brought its typical enthusiasm to this year's gathering. Activities began on Wednesday evening with a sumptuous cocktail reception at the home of Ruth and Roman DeSanctis, which set the style in terms of both cuisine and conviviality for the weekend ahead.

On Thursday, Mitch Rabkin spoke at the Scientific Symposia on the topic "Trio for Patient Care, Research, and Teaching: Transposing the Key to SS Major (? Changing the Tune?)." Members of the audience learned that "SS Major" is pronounced "megabucks major."

That evening at the Alexander Parris Room atop Quincy Market, Bill Adelson put up dozens of photographic prints of classmates, taken largely during our first year at HMS. A blow-up of the official freshman photos made for a potpourri of smiles, wise comments about hair and wrinkles, and some somber remembrances

of classmates who had died. A moment of silence was observed for them as we sat down to dinner: David Abrahams, Wendell W. Batchelder, Sue Buckingham, Edgar Davis, Leon Crawford Edwards, Robert C. Goldberg, Stephen E. Hedberg, Maury Soltes, Walter Stahl, and Howard Stubblefield.

The excellent supper was followed by comments from two favorite teachers who, with their wives, had been invited to join us: Perry and Kits Culver and Cliff and Claire Barger. The highlight of the evening was the working exhibit of "teaching tools" Perry Culver resurrected from his archives—graphic materials which, for the euphemistic or faint-hearted, might be said to represent the three-legged stool of patient care, teaching, and research with which we became familiar in Perry's lab diagnosis course. Mitch Rabkin followed by reading letters from two students whose summer research had been supported by the HMS '55 research endowment fund, reinforcing our intent to continue our generous support of this important effort. The treasurer's report followed, along with a few choice bits of humor.

Friday morning brought Ben Whitehill to the fore, asking at Alumni Day activities, "How in the World Did I Get Here?" His odyssey—medical missionary in China, prison doctor at Leavenworth, and now doctor and administrator in the Indian Health Service—illustrated the true nobility of the physician's calling.

Following a congenial luncheon on the Quadrangle, many classmates reassembled at the Black Point Inn at Prout's Neck, Maine, for a splendid weekend of warm rekindling of good and old ties. The weather was kind, the lobster superb, and the clam chowder had to be tasted to be believed! Saturday evening's postprandial highlight was a slide show by Dave Fischer reviewing the activities of our 25th reunion.



By unanimous vote it was the best reunion ever, and each participant vowed to clear his or her schedule for the 35th in 1990. We plan to get contemporary individual photos for that occasion, and publish them side by side against the *Aesculapiad* '55 originals which Dick Miller has salted away. And we'd like to encourage chil-

dren and grandchildren to participate in the 35th, since those offspring who joined us this year were a wonderful addition to the splendid crowd of HMS '55 who made our 30th such a memorable reunion.

—Mitch Rabkin and
Roman DeSanctis



25th Reunion

Those of HMS '60 who met again at the Quadrangle near the Circle of Tugo experienced the nostalgia of previous reunions along with a deep sense of pride in the accomplishments of our classmates. Festivities began with the Thursday Symposium, chaired by class president George Bernier. We heard presentations by Art Bank, Mike Frank, Phil Leder, Brigid Leventhal, and Hiram Polk. These synopses of years of research highlighted the class's arrival at the center of academic and creative life. That evening we dined at the downtown Harvard Club. From the 38th-floor vantage point we saw how the city had changed, and learned how some classmates had not.

Alumni Day found the faithful listening to addresses by three more classmates: Roger Bulger, Bob Replogle, and Dave Segel. Again a feeling of pride. These ceremonies were chaired by Joe Barr who, with George

Bernier, presented a \$40,000 check from our class to the school as "partial payment" for so much we have received. We were also able to see some professors we still revere: William Castle, Arthur Hertig, and Cliff Barger. Memories.

Following the Alumni Day luncheon about 60 people drove down East to the Stage Neck Inn in York Harbor, Maine. The setting is marvelous. The inn is perched on a point of land jutting into the sea, and it has all accoutrements required for a successful vacation: spacious rooms overlooking the water, excellent food in gracious surroundings, function rooms, swimming pool, the ocean, and, of course, tennis courts. Since the establishment is really rather small, we easily overwhelmed it and consequently had ample opportunity to mingle. Friday night cocktails were served outside on the lawn so we could still bask in the sun's warmth.

On Saturday after breakfast several participated in a tennis round robin, others joined in a bird walk, some hiked a shore trail, some shopped

in nearby Perkin's Cove, and a few braved Maine temperatures and swam in the ocean. We gathered for supper at a nearby clambake establishment, where the long tables were laden with rocks. Rocks may be primitive lobster-shell crackers, but they are quite effective. Before we broke up there was some lusty singing of "Gaudeamus Igetur."

Back at the inn we turned our attention to emptying some bottles of champagne and listening to a tape of our fourth-year Aesculapian Show which Bob Replogle had remembered to bring along. Sunday morning was spent loitering over breakfast, watching the dense fog roll by, and expressing our farewells and guarantees for the next reunion.

The mood for the entire weekend was upbeat. Even the characteristically phlegmatic were enthusiastic. Some suggested meeting sooner than the next pentad. There was obvious pride in our class, in HMS, perhaps even in ourselves. I'm sure Joe Barr will trade on this good will when he next calls on us. Even more important, however, we now have new memories that only Alzheimer's can erase, and we wish all of you had been there to share them with us.

—Richard A. Kingsbury

20th Reunion

No doubt about it, our hats are off to Jim and Linda Wallace as the host and hostess with the "mostest" who made our 20th reunion a truly memorable event.

They started the weekend off early Thursday night with a delightful cocktail party at their Cambridge home, where we reconvened from across the country. It was good to see Stan and Marianne Wishner from Los Angeles, Dave McKay from San Francisco, Marty and Beth Greene from Seattle, Bob and Roman Beck from San Antonio, Ken and Judy Ratzan from Miami, and Bill Davidson from Baltimore; and from the local area, Nelson and Mimi Burstein, Arthur and Janet Reider, Charlie Langston, and Clyde Crumpacker. Judging from the unique nametags made by the Wal-



laces from our yearbook photos, either after 20 years our eyes kindly blur out the changes, or time has not left much of a mark on most of us.

At Alumni Day on the Quadrangle, we were joined by Elliot Gershon, John and Judy Carmody and their daughter, Bob and Barbara Trelstad,

Terry and Joan Langer, Paul Cox, and Stephen Wolfe.

Friday night in the dignified atmosphere of the Tavern Club, the unusually large table easily accommodated all of us plus some welcome additions: Bill Clark, Dick Aadalen, John and Florence McNamara, Tom Smith, and Barry Levine.

Saturday Jim Wallace awoke at daybreak and low tide to start the fire and gather seaweed and mussels for a real old-fashioned New England clambake which he and Linda catered all by themselves at their Cohasset home. Glenn and Marlys Haughie, Henry and Ginger Godfrey, the Bernsteins, Bill Barry, and Larry Krenis rounded out our reunion party. Now that many of our children are in high school and college, not as many as at previous reunions accompanied their parents, but the Heafitz clan, the Bernsteins, Godfreys, Wishners, and Krenises enjoyed one another's company as they collected nature's treasures along the shore. Lobsters and clams never tasted so good, and many of us lingered on till almost sunset.

Not much has changed in the last five years. Many of us are struggling with the reality of rising college tuition vs. relatively fixed physicians' and professors' incomes, although some of us are still raising nursery and elementary school youngsters.

We missed many of you at this reunion, but we vowed to get you all out for the big one: believe it or not, our 25th!

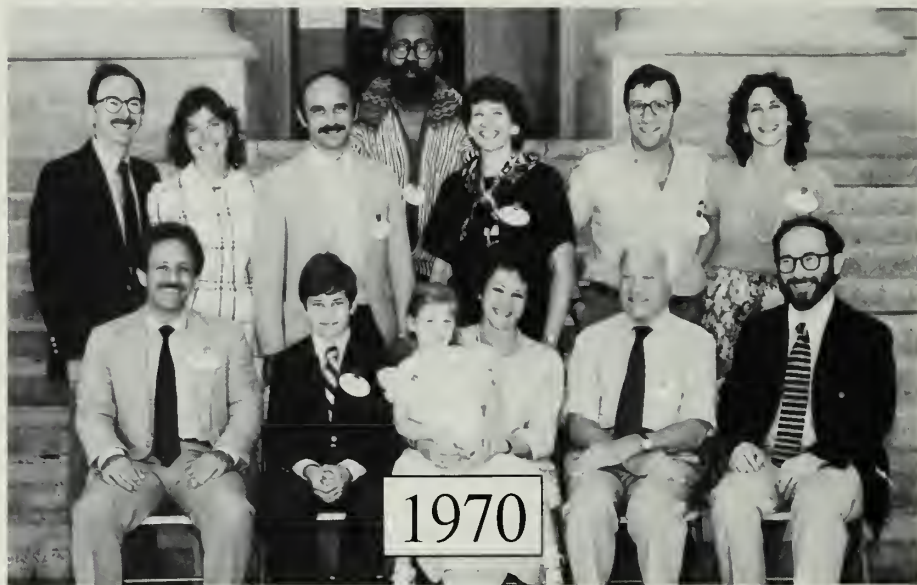
—Lesley Bunim Heafitz

15th Reunion

HMS '70, the maturing but still happy class, convened for its 15th reunion with activities that included a fine evening of cocktails and dinner at the Parris Room in the Great Hall at Quincy Market on Friday evening. Fifty people attended, including beloved class adviser Hermann Lisco and his wife.

On Saturday we had a delightful picnic, despite threatening skies, at the Park School in Brookline. There were children without number; the final count of people in attendance there will await the arrival of Mike Good's official group photo.

Longest trip prize went to Noel Solomons, who flew in from Central America. Steve and Suki Raskin won the prize for most moves since graduation, but now seem happily settled in Bluefield, West Virginia. Prize for



most work done for the reunion went to Tony Davies, whose organizing and accounting skills made it all possible.

In general, as always, a good time was had by all. We lament the ab-

sence of those who couldn't make it and hope we can all keep in closer touch.

—Michael B. Millis



10th Reunion

The 10th reunion of the Class of 1975 came as somewhat of a surprise to all of us, I'm sure. It doesn't seem 10 years since we left the hallowed halls of HMS. Those who did return to

Boston enjoyed seeing people they had not seen since the last reunion, or since graduation in 1975.

In addition to the organized events, the Class of 1975 had its own itinerary, including a scientific symposium put on by the class on Thursday. This symposium, organized primarily by David Zaleske, provided an opportu-

nity for class members to see what strides their classmates have made in their careers. The topics ranged from the esoteric—such as mathematical analysis of the electrocardiogram to characterize cardiorespiratory regulation and stability—to the more practical aspects of diagnosing filariasis by circulating parasitic antigen, which should have worldwide applications.

Following this meeting we all retired to Tobin Gerhart's, where we had a wonderful cocktail party at which we reacquainted ourselves with our classmates. Friday's dinner party at Anthony's Pier Four was also enjoyed by everyone. The weekend culminated with a clambake at the Castle Hill reserve in Ipswich. The rain stayed away long enough for us all to have a good time on the beach.

It was quite interesting to note the changes in most of our lives since the last reunion. There seems to be more stability in our lives since most of us have completed residency and have gone into practice. I wonder what the next five years hold for us. We will all find out at our next reunion.

—Preston R. Black

Fifth Reunion

CC: This was the fifth Harvard Medical School reunion for a very diverse yet still cohesive class (referred to as "1980"), who presented with the chief complaint of, "We just don't see each other often enough."

HPI: The class was in its usual state of excellent health when it gathered together on the Quadrangle for its traditional reunion photograph. Those not pictured were apparently home fasting in preparation for a Chinese banquet at Ho-Yuen-Ting in downtown Boston. Twelve courses and several hours later, the class left the restaurant but remained eager for more activities. Therefore a therapeutic reunion procedure was performed: an afternoon open house and light supper at the home of Dennis and Cynthia Lund in Marblehead which successfully brought together classmates from all over the country. Over 40 classmates plus numerous spouses and children gathered to fill in the gaps since the last clinical rotation at HMS. From as far as Cali-



fornia to as near as Boston, stories of residency were exchanged—many too risque to be included in this report, but to be even more embellished at our 10th.

The prognosis for a 10th reunion is excellent, although it is expected

that many of us won't wait that long and will get together on a p.r.n. basis long before then. Thanks again to everyone who helped make this year's reunion an overwhelming success.

—Lewis First



The Travel Program Of

Alumni Flights Abroad

This is a private travel program especially planned for the alumni of Harvard, Yale, Princeton and certain other distinguished universities. Designed for the educated and intelligent traveler, it is specifically planned for the person who might normally prefer to travel independently, visiting distant lands and regions where it is advantageous to travel as a group. The itineraries follow a carefully planned pace which offers a more comprehensive and rewarding manner of travel, and the programs include great civilizations, beautiful scenery and important sights in diverse and interesting portions of the world:

TREASURES OF ANTIQUITY: The treasures of classical antiquity in Greece and Asia Minor and the Aegean Isles, from the actual ruins of Troy and the capital of the Hittites at Hattusas to the great city-states such as Athens and Sparta and to cities conquered by Alexander the Great (16 to 38 days). **VALLEY OF THE NILE:** An unusually careful survey of ancient Egypt that unfolds the art, the history and the achievements of one of the most remarkable civilizations the world has ever known (19 days). **MEDITERRANEAN ODYSSEY:** The sites of antiquity in the western Mediterranean, from Carthage and the Roman cities of North Africa to the surprising ancient Greek ruins on the island of Sicily, together with the island of Malta (23 days).

EXPEDITION TO NEW GUINEA: The primitive stone-age culture of Papua-New Guinea, from the spectacular Highlands to the tribes of the Sepik River and the Karawari, as well as the Baining tribes on the island of New Britain (22 days). The **SOUTH PACIFIC:** a magnificent journey through the "down under" world of New Zealand and Australia, including the Southern Alps, the New Zealand Fiords, Tasmania, the Great Barrier Reef, the Australian Outback, and a host of other sights. 28 days, plus optional visits to South Seas islands such as Fiji and Tahiti.

INDIA, CENTRAL ASIA AND THE HIMALAYAS: The romantic world of the Moghul Empire and a far-reaching group of sights, ranging from the Khyber Pass and the Taj Mahal to lavish forts and palaces and the snow-capped Himalayas of Kashmir and Nepal (26 or 31 days). **SOUTH OF BOMBAY:** The unique and different world of south India and Sri Lanka (Ceylon) that offers ancient civilizations and works of art, palaces and celebrated temples, historic cities, and magnificent beaches and lush tropical lagoons and canals (23 or 31 days).

THE ORIENT: The serene beauty of ancient and modern Japan explored in depth, together with the classic sights and civilizations of southeast Asia (30 days). **BEYOND THE JAVA SEA:** A different perspective of Asia, from headhunter villages in the jungle of Borneo and Batak tribal villages in Sumatra to the ancient civilizations of Ceylon and the thousand-year-old temples of central Java (34 days).

EAST AFRICA AND THE SEYCHELLES: A superb program of safaris in the great wilderness areas of Kenya and Tanzania and with the beautiful scenery and unusual birds and vegetation of the islands of the Seychelles (14 to 32 days).

DISCOVERIES IN THE SOUTH: An unusual program that offers cruising among the islands of the Galapagos, the jungle of the Amazon, and astonishing ancient civilizations of the Andes and the southern desert of Peru (12 to 36 days), and **SOUTH AMERICA,** which covers the continent from the ancient sites and Spanish colonial cities of the Andes to Buenos Aires, the spectacular Iguassu Falls, Rio de Janeiro, and the futuristic city of Brasilia (23 days).

In addition to these far-reaching surveys, there is a special program entitled "EUROPE REVISITED," which is designed to offer a new perspective for those who have already visited Europe in the past and who are already familiar with the major cities such as London, Paris and Rome. Included are medieval and Roman sites and the civilizations, cuisine and vineyards of **BURGUNDY AND PROVENCE;** medieval towns and cities, ancient abbeys in the Pyrenees and the astonishing prehistoric cave art of **SOUTHWEST FRANCE;** the heritage of **NORTHERN ITALY,** with Milan, Lake Como, Verona, Mantua, Vicenza, the villas of Palladio, Padua, Bologna, Ravenna and Venice; a survey of the works of Rembrandt, Rubens, Van Dyck, Vermeer, Brueghel and other old masters, together with historic towns and cities in **HOLLAND AND FLANDERS;** and a series of unusual journeys to the heritage of **WALES, SCOTLAND AND ENGLAND.**

Prices range from \$2,225 to \$5,895. Fully descriptive brochures are available, giving the itineraries in complete detail. For further information, please contact:

Alumni Flights Abroad

Department HMS 25
A.E.A. Plaza 425 Cherry Street
Bedford Hills, NY 10507
TOLL FREE 1-800-AFA-8700
N.Y. State (914) 241-0111